PATIENT / FAMILY INFORMATION SHEET

CHILDREN TO BE RECEIVING HEALTH CARE AT UPPER VALLEY PEDIATRICS		
NAME	**DATE OF BIRTH**	**GENDER**
1)		
2)		
3)		
4)		

PLEASE ANSWER THE 3 QUESTIONS BELOW – IF DIFFERENT FOR EACH CHILD PLEASE USE #S ABOVE TO INDICATE:

1) ETHNICITY		NOT HISPANIC OR LATINO		HISPANIC OR LATINO		PREFERS NOT TO ANSWER
		AMER.INDIAN / AL NATIVE		ASIAN		BLACK/AFRICAN AMERICAN
2) RACE		NATIVE HI/PACIFIC ISLANDS		WHITE		PREFERS NOT TO ANSWER
3) PREFERRED LANGUAGE:						OTHER RACE: SPECIFY

4) HEARING/VISION IMPAIRED: (INDICATE CHILD/CHILDREN)

IF CUSTODY, GUARDIANSHIP, OR SHARING OF INFO (ETC.) WITH OTHER PARENT/PARTIES IS AN ISSUE PLEASE STATE:

(Please provide copies of court order(s) as applicable.)

PARENT / GUARDIAN INFORMATION:
(IF OTHER THAN BIOLOGICAL PARENT/S PLEASE SPECIFY RELATIONSHIP IN OTHER)

CHILD'S MOTHER:	**CHILD'S FATHER:**
OTHER:	OTHER:
MAILING ADDRESS:	MAILING ADDRESS:
CITY: STATE & ZIP:	CITY: STATE & ZIP:
PRIMARY PHONE #:	PRIMARY PHONE #:
CELL PHONE #	CELL PHONE #
WORK/OTHER PHONE #	WORK/OTHER PHONE #
E-MAIL ADDRESS:	E-MAIL ADDRESS:

WHERE DO CHILDREN PRIMARILY RESIDE:

TO WHAT ADDRESS SHOULD BILLS &/OR CORRESPONDENCE BE SENT:

INSURANCE / PAYMENTS / FEES ETC.

PLEASE NOTE: A COPAY IS DUE AT CHECK-IN AT EVERY VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

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PRIMARY INSURANCE INFORMATION:

COMPANY:	POLICY EFFECTIVE DATE:
POLICY HOLDER:	POLICY HOLDER'S D.O.B.
INSURANCE ID #	INSURANCE GROUP #

SECONDARY INSURANCE INFORMATION:

COMPANY:	POLICY EFFECTIVE DATE:
POLICY HOLDER:	POLICY HOLDER'S D.O.B.
INSURANCE ID #	INSURANCE GROUP #

THE FEE FOR A "NO SHOW" VISIT IS $25.00 OR $50.00 DEPENDENT UPON LENGTH OF TIME SAVED FOR YOU.
A "NO SHOW" FEE may be charged for any visit not kept without 24 hours advance notice.

I certify that I, or my dependents above, have insurance coverage as indicated above and assign directly to Upper Valley Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions as well as to release information necessary for the payment of claims:

DATE SIGNED:	SIGNATURE:

UVP OFFICE USE:	√	Date	NOTES:
HIPPA PRIVACY FORM SIGNED & SCANNED:			
INSURANCE CARDS SCANNED:			
RECORDS RELEASE SIGNED, SCANNED, & SENT:			