PATIENT / FAMILY INFORMATION SHEET

[A] CHILD(REN) TO BE RECEIVING HEALTH CARE AT UPPER VALLEY PEDIATRICS:

PATIENT NAME (full legal name)	GENDER	DATE OF BIRTH
1)		
2)		
3)		
4)		
5)		

[B] REQUIRED INFORMATION – IF DIFFERENT FOR EACH CHILD PLEASE USE #S ABOVE TO INDICATE:

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

3) PREFERRED LANGUAGE:

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

[C] COMMUNICATION PREFERENCE / APPOINTMENT CONFIRMATION

*INDICATE YOUR PREFERRED METHOD OF RECEIVING APPOINTMENT CONFIRMATIONS:

	PHONE CALL (INDICATE #):
	TEXT (INDICATE #):
	EMAIL (INDCIATE EMAIL ADDRESS):

[D] PARENT / LEGAL GUARDIAN INFORMATION:

IF OTHER THAN BIOLOGICAL PARENT(S) COMPLETE REVERSE SIDE OF THIS FORM

NAME:	NAME:
RELATIONSHIP TO PT:	RELATIONSHIP TO PT:
MAILING ADDRESS	MAILING ADDRESS
CITY STATE & ZIP	CITY STATE & ZIP
EMAIL ADDRESS	EMAIL ADDRESS
PRIMARY PHONE #	PRIMARY PHONE #
CELL / OTHER #	CELL / OTHER #

WHERE DO CHILDREN PRIMARILY RESIDE?

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

IF **CUSTODY/GUARDIANSHIP/SHARING OF INFO** (ETC) WITH OTHER PARENT/PARTIES IS AN ISSUE PLEASE STATE & PROVIDE COPY OF LEGAL DOCUMENTATION:

[E] INSURANCE / PAYMENTS / FEES, ETC

PLEASE NOTE COPAYS ARE DUE AT CHECK-IN AT EVERY VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

PRIMARY INSURANCE INFORMATION:	
INS COMPANY	COPAY AMOUNT
POLICY HOLDER NAME	POLICY HOLDER DOB
POLICY HOLDER'S EMPLOYER	POLICY EFFECTIVE DATE
INSURANCE ID #	INSURANCE GROUP #
SECONDARY INSURANCE INFORMATION:	
INS COMPANY	COPAY AMOUNT
POLICY HOLDER NAME	POLICY HOLDER DOB
POLICY HOLDER'S EMPLOYER	POLICY EFFECTIVE DATE
INSURANCE ID #	INSURANCE GROUP #

PLEASE COMPLETE REVERSE SIDE FOR MINORS IN DCF CUSTODY, FOSTER CARE &/OR LEGAL GUARDIANSHIP

SIGNATURE REQUIRED ON BACK SIDE OF FORM

[F] FOSTER CARE PROVIDER / LEGAL GUARDIAN INFORMATION:	
NAME:	
RELATIONSHIP:	
MAILING ADDRESS	
CITY	STATE & ZIP
EMAIL ADDRESS	
PRIMARY PHONE NUMBER	
CELL / WORK / OTHER	

	WE MUST RETAIN COPY OF LEGAL DOCUMENTATION / COURT ORDERS i.e. Court Ordered Certificate of Appointment **(REQUIRED)**		
DATE FOSTER CARE BEGAN		EXPECTED LENGTH OF CARE	

	INDICATE IF INFORMATION SHARING IS TO BE RESTRICTED – PROVIDE PARTIES NAMES AND DETAILS: i.e. Biological Mother: Jane Doe – no contact allowed – is not to be provided any information

[G] CASE WORKER INFORMATION	
CASE WORKER'S NAME:	**PHONE #**
DCF OFFICE:	**PHONE #**

[H] ALTERNATE AUTHORIZED INDIVIDUAL I authorize the following (step-parent, grandparent, daycare – someone other than biological parents or legal guardians) to seek medical care, obtain medical information, and/or discuss medical treatment of the above-named child until further written notice by me	
NAME	
RELATIONSHIP TO PATIENT	
PHONE NUMBER	
AUTHORIZATION FORM COMPLETED & SIGNED	

IN ORDER TO KEEP ACCURATE RECORDS, WE REQUEST THAT THE FOSTER PARENT INFORM US WHEN THE FOSTER CHILD IS NO LONGER IN THEIR CARE.

PLEASE PROVIDE 24 HOURS ADVANCED NOTICE FOR CANCELLING A SCHEDULED VISIT. MISSED OR LATE CANCELLED VISITS WILL RESULT IN A FEE OF $25 OR $50 DEPENDENT UPON VISIT TYPE/LENGTH
AUTHORIZATION AND RELEASE: I authorize the providers of Upper Valley Pediatrics (UVP) to asses and treat the above-named patient(s). I also authorize UVP to release any information including diagnosis/treatment/examination rendered during the period of such care to third party payors and/or health providers. I authorize and request that my insurance company pay directly to UVP the benefits otherwise payable to me. I understand that my insurance carrier may not cover all services provided or ordered. I agree to be responsible for the payment of all services rendered on behalf of the above-named dependents. *In accordance with Upper Valley Pediatrics Financial Policy.
DATE SIGNED:
SIGNATURE: