HEALTHY STEPS PEDIATRICS LLC

Patient Name_____

Date of Birth_____ Circle one: Male / Female

Address_____ Apt _____

City_____ State_____ Zip_____

Preferred Pharmacy Name_____

Pharmacy Location_____

PARENT/LEGAL GUARDIAN INFORMATION

Mother_____ DOB_____ Maiden Name_____

Address (if different from child) _____ Home

#_____ Cell #_____ Work #_____

Email_____

Father_____ DOB_____

Address (if different from child)_____ Home

#_____ Cell #_____ Work #_____

Email_____

Additional persons authorized to bring child in for medical treatment. **children under 17 years of age must be accompanied by an adult**

Name_____ Phone #_____ Relation_____

Name_____ Phone #_____ Relation_____

Name_____ Phone #_____ Relation_____

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to referred specialists and to my insurance company, if applicable. I allow fax transmittal of my child's medical records.

I authorize and request that insurance payment be made directly to HEALTHY STEPS PEDIATRICS, LLC, should they elect to receive such payment. I acknowledge that I am ultimately financially responsible for my child's account. I authorize Healthy Steps Pediatrics to download medication histories from the pharmacy.

I have read and fully understand the above consent for treatment, release of medical records, insurance authorization and account financial responsibility.

Date_____ Signature_____