

2010 *Nevada Pediatric Specialists* **Date:**
Patient Information Form

Referred by: Website Yellow Pages Friend/Family OBGYN Provider List Walk In

Patient's Info: Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____ Age: _____ Male/Female _____

Mother's Info: Last Name _____ First Name: _____ SS# _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Marital Status: _____ Employer: _____

Home Phone: _____ Mobile #: _____ Other #: _____

Father's Info: Last Name _____ First Name: _____ SS# _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ Marital Status: _____ Employer: _____

Home Phone: _____ Mobile #: _____ Other #: _____

Primary Insured's Name: _____ Relationship to Patient: _____

SS#: _____ DOB: _____

Insurance Co Name: _____ ID#: _____ Group #: _____

Insured's Employer: _____ Employer Phone #: _____

Contact in Case of Emergency: (other than parents) _____ Phone: _____

Sibling Name: _____ DOB: _____ Age: _____

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YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. REGARDLESS OF INSURANCE COVERAGE! PLEASE READ THE FOLLOWING CAREFULLY! BY SIGNING BELOW, YOU INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THE FOLLOWING POLICIES:

1. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize the release of medical records for the purpose of medical referrals, and to the persons listed above on this form.
2. I authorize payment of medical benefits from my insurance company or government program to Nevada Pediatric Specialists.
3. I agree to pay all insurance co-pays and/or coinsurance at the time of check-in and prior to services being rendered.
4. If Nevada Pediatric Specialists cannot verify my insurance at the time of visit, or if I do not bring current proof of insurance to each visit, I agree to pay charges in full before the patient is seen.
5. If any charges incurred by me or my dependents are submitted to a collection agency, I agree to pay all fees including, but not limited to both, the collection agency fee and the account balance.
6. If I miss any appointments without prior notification to this office, I agree to pay a \$25.00 no show charge.
7. I agree to pay a \$25.00 charge, in addition to the check amount, on any of my personal checks which are returned to this office by my bank.
8. I understand that Nevada Pediatric Specialists bills insurance as a courtesy. I understand that my financial charges for services rendered by Nevada Pediatric Specialists are ultimately my responsibility.
8. While your appointment maybe for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. Nevada Pediatric Specialists makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. I agree not to hold Nevada Pediatric Specialists responsible in any manner for time spent waiting to be seen.

Responsible Party (Print) _____ Sign: _____ Date: _____

**Nevada Pediatric Specialists
Quality Healthcare for Children**

Nombre del Paciente: _____ **Fecha De Nacimiento** _____ **Fecha De Hoy:** _____

Autorización/Consentimiento Para su Tratamiento:

Doy autorización a la oficina de **Nevada Pediatric Specialists** para que le provean cualquier tratamiento medico necesario, ya sea tratamiento regular o de emergencia, como sea determinado por el doctor y en cuanto sea la major decision e interes para a mi hijo/hija, siendo un/una menor de edad. Esta autorizacion continuara asta que yo la cancele o revoque en escrito.

Firma del Padre/Madre/Guardian Legal/Representante

Fecha: _____

Farmacia de Preferencia:

Para su conveniencia **Nevada Pediatric Specialists** tiene la habilidad de mandar su receta medica via correo electronico, o si usted lo desea, le podemos proveer su receta medica en papel.

Nombre de su Farmacia: _____ # de Teléfono: _____

Yo autorizo esta farmacia para que transmitan informacion medical via correo electronic. Esta autorizacion continuara asta que yo la cancele o revoque en escrito

Firma del Padre/Madre/Guardian Legal/Representante

Fecha: _____

Autorización Para Obtener Información Medica del Paciente Siendo un Menor de Edad:

Les doy autorización a las siguientes personas o agencias para que autorizen tratamiento medico y firmen en caso de mi ausencia por mi hijo/hija siendo menor de edad.

Nombre Completo: _____

Relación al Paciente: _____

Nombre Completo: _____

Relación al Paciente: _____

Firma del Padre/Madre/Guardian Legal/Representante

Fecha: _____

Autorización para Obtener Expedients Medicos

Nombre Complete del Paciente: _____

Fecha De Nacimiento _____

Número de Teléfono del Padre/Madre/Guardian: _____

***Nevada Pediatric Specialists
Quality Healthcare for Children***

Autorización Para Obtener Expedientes Medicos del Paciente De su Doctor Anterior Siendo un/una Menor de Edad

Nombre de su Doctor Anterior: _____

Nombre de la Oficina: _____

Número de Teléfono: _____

Número de Fax: _____

Para nuestra oficina:

Nevada Pediatric Specialists
3201 S. Maryland Parkway Suite 608
Las Vegas, NV 89109
Tel: (702)457-5437
Fax: (702) 464-5801

Favor de mandar todos los expedients medicos e incluya expediented de vacunas, notas medicas, notas de operaciones, resultados de radios X, analisis de laboratorio y examines diagnosticos.

Con mi firma, yo autorizo el cambio de todos los expedients medicos. Yo entiendo y acepto los terminos de esta autorización siendo que toca la protección de informacion medica. (PHI)

Padre/Madre/Guardian: _____ **Fecha de Hoy:** _____