Please print this form, complete it and bring it with you to your next appointment. Do Not E-Mail

CENTRAL OHIO PRIMARY CARE

PATIENT DEMOGRAPHIC INFORMATION - PEDIATRIC

Please Complete This Entire Form. Thank You!

Today's Date: _____/_____/____ **Referred by *(If Applicable)*: _____**

CHILD INFORMATION

OFFICE USE (P#):

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH *(mm/dd/yyyy)*:
MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS *(If different from mailing address)*:	CITY:	STATE:	ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:
E-MAIL ADDRESS: □ None □ Prefer Not To Disclose	USE E-MAIL ADDRESS FOR PATIENT PORTAL: □ Yes □ No □ Not Applicable	SOCIAL SECURITY # *(If applicable)*:	
GENDER: □ Male □ Female □ Transgender □ Unknown	RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Hispanic □ Native Hawaiian/Other Pacific Islander □ White □ Refuse to Report □ Other		
ETHNICITY: □ Hispanic/Latin □ Non-Hispanic/Latin □ Refuse to Report	PREFERRED LANGUAGE: □ English □ Spanish □ Other *(Please specify)*:		

PARENT/LEGAL GUARDIAN #1 - GUARANTOR

(Individual responsible for bills and payment) OFFICE USE (Account #):

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO CHILD *(Check all that apply)*: □ Mother □ Father □ Legal Guardian □ Stepmother □ Stepfather □ Other *(Please specify):*	
STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP	
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:	
E-MAIL ADDRESS: □ None □ Prefer Not To Disclose	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:		
GENDER: □ Male □ Female □ Transgender □ Unknown	EMPLOYER NAME:	EMPLOYER PHONE #: ( )		

PARENT/LEGAL GUARDIAN #2

LAST NAME:	FIRST NAME:	RELATIONSHIP TO CHILD *(Check all that apply)*: □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Primary Care Giver □ Other (*Please specify*):	
STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	

ALTERNATE EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	RELATIONSHIP *(Please specify)*:
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

ADDITIONAL CONTACT #3 (OPTIONAL)

LAST NAME:	FIRST NAME:	RELATIONSHIP TO CHILD *(Check all that apply)*: □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Primary Care Giver □ Other (*Please specify*):	
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No	

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: □ Yes □ No *(Self Pay)*			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION:	SUBSCRIBER:	RELATION:
GENDER: □ Male □ Female □ Transgender □ Unknown		GENDER: □ Male □ Female □ Transgender □ Unknown	
DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from COPC in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check All That Apply*):	**POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select Only One*):**
□ Home Phone of Record □ Brief □ Extended □ Cell Phone of Record □ Brief □ Extended □ Work Phone of Record □ Brief □ Extended	□ Mailing Address of Record □ Street Address of Record □ Other: _____ Street Address City State Zip

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at COPC which outlines my privacy rights and how COPC may use and disclose Protected Health Information about me.

□ Yes □ No □ Offered but Decline Initials: _____

Photograph for Patient Identification

I give my consent to the use of my photograph for identification on my electronic health record. **□ Accept □ Decline Initials: _____**

Telephone Contacts, Monitoring and Recording-this does not include calls related to appointments, billing or health-related information

I hereby consent and agree that: (1) any calls with COPC may be monitored and/or recorded and that COPC (or anyone acting on COPC's behalf) may contact me, from time to time, regarding my Account (including for collections purposes or related to insurance coverage); (2) any and all of COPC's contacts with me may be made via text message or with an automated dialing and announcing or similar device; (3) COPC may contact me at any telephone number I provide to them, whether a residential or business number, a wireless, cellular or mobile number (including a telephone number converted to a mobile/wireless number, or which connects to any type of mobile/wireless device); (4) I have an established business relationship with COPC and that COPC may contact me at the telephone number I provide to them, in any of the ways described above. I understand that, if I accept now, I may opt-out at any time by notifying the COPC EHR Department.

□ Accept □ Decline Initials: _____

Health Information Exchange (HIE)

COPC participates in one or more Health Information Exchanges that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. I agree that my COPC provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the COPC EHR Department or my physician.

All COPC patients are automatically enrolled in the HIE unless the Opt Out box is checked and initialed. **□ Opt Out Initials: _____**

Confidential Communications

I understand COPC will notify me if COPC is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Insurance Assignment and Acknowledgement

I understand my insurance carrier can choose to assign benefits to COPC or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment.*

I certify that I will pay to COPC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to COPC any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

By signing below, I am acknowledging that I have read and understand the above statements.

_____	_____	_____
Parent or Legal Guardian Printed Name	**Parent or Legal Guardian Signature**	**Date Signed**

- ***PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD***