Sewanee Pediatric and Adolescent Medicine

Preferred Provider –
Circle One: Amy Evans MD / Mary Heath, MD / Eric Bornemann, CPNP

Child/Patient Name ____
Last / First / Middle / Preferred Name

Birthdate:____________ Social Security #:____________ Patient cell: ______________ (16 years and older) Gender:__________ Male/Female

Mailing Address: ______________________________ City/State/ Zip______________________________

Mother's Name:____DOB:____________________

Mother's address if different from patient: ____

Social Sec #:________________________Phone: ____________________

Father's Name:____DOB:____________________

Father's address if different from patient: ____

Social Sec #:________________________Phone: ____________________

Legal Guardian's Name:____DOB:____________________

Address if different from patient: ____

Social Sec #:________________________Phone: ______________

Preferred Email address: ____________________Preferred Contact Method: Home phone/Cell phone/Text /Email

We will make every effort to contact you to confirm your appointment, if you do not confirm we have the right to schedule another appointment in your allotted time and you may be asked to reschedule. If your appointment is not cancelled or rescheduled following our cancellation policy guidelines you will be charged a $20 missed appointment fee. It is your responsibility to make sure that we have your correct phone number.

Preferred Pharmacy:____
Name / Location

Race: (Circle One) American Indian/Alaskan Native, Asian, Black/African American, Nat Hawaiian/Pacific Islander, White
Declined, Other ____________

Ethnicity: (Circle One) Hispanic or Latino, Not Hispanic or Latino, Declined

Preferred Language: English, Spanish, or Other__________________

Living With (Circle One) Both Parents Mother Father Other ______________________________
Name/Relationship

Copays and balances will be due date of service. Person who brings child will be responsible for copays and balances. Any copay not paid on date of service will be charged a $10 late copay fee. We require a credit card to be kept on file.

Emergency Contact:________________________Relationship____________Phone____________________

Primary Insurance: Must have a copy. If we do not have correct information including secondary, you could be responsible for any balances this may generate.

Name of Person Carrying Insurance:________________________________DOB:________________

Insurance Company:________________________________Employer:________________________

OVER

Policy Number:______________________________ Group Number:______________________

Secondary Insurance: Must have a copy.

Name of Person Carrying Insurance:______________________________ DOB:______________

Insurance Company:______________________________ Employer:______________________

Policy Number:______________________________ Group Number:______________________

List other family members living in the household, name and relationship.

1) ______________________________ 2) ______________________________

3) ______________________________ 4) ______________________________

Custody: Who has custody, name & relationship______________________________
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child, obtaining information about the child's medical treatment or receiving a copy of child's records?

Yes or No: If yes please explain and provide a copy of any legal paperwork that supports this restriction.

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List any person that has permission to bring your child to be seen in our office. Indicate whether they may consent for all care including immunization and lab work.

Name: ______________________________ Care: all/ other ______________________

Name: ______________________________ Care: all/ other ______________________

Any person accompanying your child is responsible for charges incurred on the day of service including copays. If someone not listed above needs to bring your child, you must send a signed note or call giving our office permission to treat.

We have providers on call 24/7, please call our office prior to going to urgent care.

Notice of Deemed Consent of HIV testing:

Pursuant of TN Law, if any staff member is exposed to blood or bodily fluid from my child, I give consent for my child to be tested for HIV.

Parent/Legal Guardian: ______________________ Date: ______________________

Authorization and release, Assignment of Benefits

I hereby authorize you to release any written, and/or verbal information regarding the treatment of my child to third party payors. I authorize my insurance company to pay benefits directly to Sewanee Pediatrics. I agree to be responsible for all services rendered, not covered by my insurance carrier and any associated collection fees.

I hereby authorize Sewanee Pediatrics and their Physician Extenders to conduct and direct my child's medical care. I also authorize Sewanee Pediatrics staff, directed by the Physician, to give medications, perform diagnostic procedures and provide other care which, in the judgement of the physician, is required for my child's best care and treatment.

Signature______________________________ Date______________________

Relationship to Patient______________________________