JONESBOROPEDIATRICCLINIC
newborn to adolescence

Patient information

Patient's Last Name: _____

First Name: _____

Social Security No.: _____

Date of Birth: _____

Specialty Care Providers
(i.e. Eyes, Ears, Behavior, ACH/Lebonheur Teams, Therapies, etc.)

_____
Name Specialty/Location

_____
Name Specialty/Location

_____
Name Specialty/Location

_____
Name Specialty/Location

Who can we Thank for the referral?

_____

GUARANTOR INFORMATION -

Parent whom carries patient insurance

Name:_____

Address:_____

_____

Relationship to patient:_____

Date of Birth: _____

Social Security No.: _____

Cell Phone: _____

E-mail:_____

Guarantor Employer: _____

PARENT INFORMATION

Mother's Name: _____

Mother's Mobile Phone: _____

Father's Name: _____

Father's Mobile Phone: _____

Medical / Financial Information Disclosure

I understand that authorization to anyone other than myself and child's other parent is voluntary and I can revoke authorization at any time.

I, _____, the undersigned, hereby authorize Jonesboro Pediatric Clinic, LLC, its representatives, providers and staff, to share any and all medical and financial information with the following individual(s). The individuals listed below are involved in my child's care and have authorization to talk to our staff on the phone and/or bring my child into the office.

Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized.

☐ **At this time I do not want to authorize anyone other than parent/guardian.**

Name/Number: _____ Relationship to Patient: _____
(example: Grandmother, Uncle, Family Friend, etc)

Name/Number:_____ Relationship to Patient: _____

Name/Number:_____ Relationship to Patient: _____

Name/Number: _____ Relationship to Patient: _____

Authorized by: X_____ _____ Date: _____
(Parent signature) (Print Parent Name)