Purohit Pediatric Clinic, LLC

516 Quintard Ave, Anniston, AL 36201 -- Phone 256-741-9799 Fax 256-741-9795
4441 Hwy 431 Ste 1, Roanoke, AL 36274 -- Phone 334-863-2553 Fax 334-863-2558
2468 Moody Parkway, Moody, AL 35004 -- Phone 205-640-1200 Fax 205-640-1005
3686 Grandview Parkway Ste 710, Birmingham, AL 35243 -- Phone 205-723-0395 Fax 205-201-6055

PATIENT INFORMATION

Patient Name			Gender Male or Female	Patient's Date of Birth
Mailing Address			City/State/Zip	
Home Phone	Cell Phone		Social Security Number	
Patient Language English - Spanish - Other	Ethnicity Hispanic - Non Hispanic - Other	Patient Race Caucasian – African American – Hispanic – Asian –Other_____		
Email Address		Preferred Method of Communication Home Phone - Email - Cell Phone - Work Phone		
Mother's Name		Mother's Date of Birth	Legal Guardian Yes or No	Phone Number
Mother's Employer	Employer Phone		Mother's Social Security Number	
Father's Name		Father's Date of Birth	Legal Guardian Yes or No	Phone Number
Father's Employer	Employer Phone		Father's Social Security Number	
Will your child receive age appropriate vaccines? Yes or No				

INSURANCE INFORMATION

Primary Insurance Carrier	Policy Holder's Name	Date of Birth
Insured ID or Contract Number	Group Number	
Secondary Insurance Carrier	Policy Holder's Name	Date of Birth
Insured ID or Contract Number	Group Number	

Please give the receptionist your insurance card and photo ID along with this form as soon as you have completed all sections. Thank You!!!

I understand that Purohit Pediatric Clinic, LLC will bill my insurance company for services rendered to me. The billing of my insurance is a courtesy provided by Purohit Pediatric Clinic, LLC and I understand and agree that I am financially responsible for all charges that are incurred when services are rendered.

Guardian Signature	Date	Relationship

Purohit Pediatric Clinic, LLC

Patient Agreement for Communications

I understand that as part of my health care Purohit Pediatric Clinic, LLC will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I herby authorize Purohit Pediatric Clinic, LLC to contact me in the following ways:

_____ Home Phone Number: _____ Message: Yes or No

_____ Cell Phone Number: _____ Message: Yes or No

_____ Office Phone Number: _____ Message: Yes or No

_____ Email Address: _____

I authorize Purohit Pediatric Clinic, LLC to speak with the following person/s and release information on my behalf. (These people will serve as emergency contacts and will be authorized to bring your child in for medical care.)

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that Purohit Pediatric Clinic, LLC will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Date_____ Patient's Name_____

Signature of Patient or Authorized Party_____

Relationship to Patient_____