

# Central Ohio Primary Care Physicians, Inc. Ohio Center for Pediatrics

Date: \_\_\_\_\_ Chart \_\_\_\_\_

**PARENT**

Name \_\_\_\_\_ BD \_\_\_\_\_ SSN \_\_\_\_\_ Rel to PT \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (Home) \_\_\_\_\_ Work/Cell \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**PARENT**

Name \_\_\_\_\_ BD \_\_\_\_\_ SSN \_\_\_\_\_ Rel to PT \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (Home) \_\_\_\_\_ Work/Cell \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**CHILDREN**

First _____	MI _____	Last Name _____	DOB _____	M/F _____
First _____	MI _____	Last Name _____	DOB _____	M/F _____
First _____	MI _____	Last Name _____	DOB _____	M/F _____
First _____	MI _____	Last Name _____	DOB _____	M/F _____
First _____	MI _____	Last Name _____	DOB _____	M/F _____

**ALLERGIES:** To be completed by physician

	_____
	_____
	_____

**COMMUNICATION PREFERENCES**

To assist in your child(ren)'s care, it may be a necessary to release their Protected Health Information to someone other than yourself. To whom may we talk?

Parent _____	PRINT NAME
Parent _____	PRINT NAME
Step-Parent _____	PRINT NAME
Other Person _____	PRINT NAME
Other Person _____	PRINT NAME

May we leave a message on:	Yes	No
Your answering machine/voicemail at home	<input type="checkbox"/>	<input type="checkbox"/>
Your voicemail at work	<input type="checkbox"/>	<input type="checkbox"/>

**Patient Responsibilities**

I understand it is my responsibility to verify with my insurance company if any and all services are covered and/or require pre-authorization. I understand that if I have a copay, it is payable at the time of service. I hereby authorize my insurance carrier to issue payment directly to Central Ohio Primary Care, Inc. all covered services that my child(ren) receive. If I do not have insurance coverage for my child(ren), I understand that payment is due at the time of service. I understand that if inaccurate information is given to Central Ohio Primary Care, Inc. and the information is not corrected until after my insurance company's timely filing limit, I will be responsible for the bill.

Signature (Relationship) \_\_\_\_\_ Date \_\_\_\_\_