Pediatric Center

Patient Information

Patient Name: _____ DOB: _____-_____-_____

Physical Address: _____ City: _____ State:_____

Zip: _____ Primary Phone Number: ____-____-_____

Email: _____

Mailing Address (if different from physical address):

_____ City: _____State:_____ Zip: _____

We are required to ask these questions, your care will not be affected by your answers.

Gender Identity: ☐Male ☐Female☐Male to Female transgender ☐Female to Male transgender ☐Genderqueer ☐ Refuse to report ☐Other:_____

Sexual Orientation: ☐Lesbian, gay or homosexual ☐Straight or heterosexual ☐Bisexual ☐ Refuse to report ☐Other:_____

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other ☐ Refuse to report

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Refuse to report

Preferred Language: ☐ English ☐ Other _____

Employment information (if applicable)

Employer: _____ Employer's Number: ____-____-_____

Insurance Information. Please fill out every time you receive this paperwork for our billers records.

Primary Insurance _____Policy Holders Name_____

Policy holders address:_____

Policy holders DOB _____-_____-_____ Policy holders phone number _____-_____-_____

Policy holders SSN _____-_____-_____

ID Number _____Group Number _____

Secondary Insurance _____Policy Holders Name_____

Policy holders address:_____

Policy holders DOB _____-_____-_____ Policy holders phone number _____-_____-_____

Policy holders SSN _____-_____-_____

ID Number _____Group Number _____

*please note we must have the policy's holders information provided or you may be responsible for payment

TURN OVER

Emergency contact
Name _____
Phone Number _____-_____-_____ Relationship to child _____

Records Release: please list your parent(s) or guardian below if you'd like us to be able to communicate with them regarding your care

I authorize The Pediatric Center to release any and all medical information to:

Name:_____Relationship: _____Phone number_____

Name:_____Relationship: _____Phone number_____

Name:_____Relationship: _____Phone number_____

Authorization Section

Texting Consent:

I authorize the Pediatric Center to communicate with me via text message and would like to receive

(please circle) **Detailed** or **Non Detailed (generic)** messages regarding my children.

Last 4 digits of primary phone # _ _ _ _

Collection Policy:
I hereby authorize the release of my (or my child's) medical information to my insurance carrier concerning me or my child's illness and treatment and hereby assign all payments for medical services to my doctor. I understand that I am responsible for any amount not covered by my insurance. If for any reason the account should become delinquent, the responsible party agrees to pay up to a twenty five percent (25%) collection fee of the unpaid balance; together with all legal fees, with or without suit, including reasonable attorney fees, legal fees and costs.
HIPPA notice:
I also acknowledge that I can access the HIPPA notice for the Medical Center for Children and Adolescents, PA (DBA as The Pediatric Center) on their website, www.mypediatriccenter.com.
No Show notice:
Out of respect to all patients and families we serve, and to enable continued access to care for all our patients, we have the following No-Show Policy effective March 3, 2026.The first no show we kindly remind you of our policy and understand life happens to everyone. The second no show a $20 fee will be applied to the guarantor's account.Third and Subsequent No-Shows: A $30 fee will be applied to the child's account for each missed appointment.No-show fees must be paid prior to scheduling any new appointments. To avoid a no-show fee, appointments must be canceled or rescheduled at least 4 hours in advance.

Signature: _____ Today's Date: _____