



**\*\*If you are a step parent, foster parent, or any other type of guardian; Please fill out number 3 of this form with your information.**

**The primary parent is the one we will contact for lab results, confirm appointments, billing questions etc. If a child is 18 years old, they will receive their own information sheet.**

1. **Primary Parent Name** \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Email (to be used to access your child's patient portal): \_\_\_\_\_

Employer \_\_\_\_\_ Employer's number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

2. **Secondary Parent Name** \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Employer \_\_\_\_\_ Employer's number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

3. **Other Guardian's Name** \_\_\_\_\_ Relationship to child \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

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

Primary Insurance \_\_\_\_\_ Policy Holders Name \_\_\_\_\_  
DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ID Number \_\_\_\_\_  
Group Number \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holders Name \_\_\_\_\_  
DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ID Number \_\_\_\_\_  
Group Number \_\_\_\_\_

**5. Emergency contact other than the parents/caregiver.**

Name \_\_\_\_\_  
Phone Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to child \_\_\_\_\_

**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 #** \_\_\_\_\_

Turn over



Please list all of the children that are 17 years old or younger. 18 year olds will receive their own information sheets. If you need more spaces, please let the front desk know.

1. Child's Name \_\_\_\_\_

In relationship to primary parent:  Biological child  Step child  Adopted child

DOB \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex \_\_\_\_ Does this child live with the Primary Parent Yes  No

If they do not live with the Primary Parent; please list their address below.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

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

Ethnicity:  Hispanic  Not Hispanic or Latino  Refuse to report Language:  English  Other \_\_\_\_\_

2. Child's Name \_\_\_\_\_

In relationship to primary parent:  Biological child  Step child  Adopted child

DOB \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex \_\_\_\_ Does this child live with the Primary Parent Yes  No

If they do not live with the Primary Parent; please list their address below.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

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

Ethnicity:  Hispanic  Not Hispanic or Latino  Refuse to report Language:  English  Other \_\_\_\_\_

3. Child's Name \_\_\_\_\_

In relationship to primary parent:  Biological child  Step child  Adopted child

DOB \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex \_\_\_\_ Does this child live with the Primary Parent Yes  No

If they do not live with the Primary Parent; please list their address below.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

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

Ethnicity:  Hispanic  Not Hispanic or Latino  Refuse to report Language:  English  Other \_\_\_\_\_

## Authorization Section

### 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

Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_



appointments. To avoid a no-show fee, appointments must be canceled or rescheduled at least 4 hours in advance.

## Minor Consent Form

Effective July 1, 2024, Idaho passed new limits on Minor Consents. In order to be compliant, we are required to have on file the individuals who you authorize to bring your child to the clinic for an appointment. You are authorizing these individuals to accompany your child(ren) to a visit and authorizing them to give consent for exam and/or treatment options including (but not limited to) x-rays, prescribing medication, immunizations etc.

Please list all children that are patients at the Pediatric Center

Name: \_\_\_\_\_

DOB \_\_\_\_\_

Name: \_\_\_\_\_

DOB \_\_\_\_\_

Name: \_\_\_\_\_

DOB \_\_\_\_\_

Name: \_\_\_\_\_

DOB \_\_\_\_\_

Name: \_\_\_\_\_

DOB \_\_\_\_\_

Please list any person allowed to accompany your child(ren) to a visit at The Pediatric Center. **If you would like your adolescent to be seen by themselves please ask for a separate form.**

**Signature:** \_\_\_\_\_ Today's Date \_\_\_\_\_



Name: \_\_\_\_\_ Phone  
#: \_\_\_\_\_

Name: \_\_\_\_\_ Phone  
#: \_\_\_\_\_

Name: \_\_\_\_\_ Phone  
#: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date \_\_\_\_\_