BIRTH & BEYOND
PEDIATRICS P.C.

PATIENT IDENTIFICATION FORM

Patient Name: ____ Referred By: ____________________________

Date of Birth: ____ /____ /____ Sex: ☐ M ☐ F SS# ______ - _____ - ______ Pharmacy: _____________________

Siblings: ____

Race: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Native HI/Pacific Is. ☐ Prefers not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefers not to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other *(please specify)*: ____

MOM'S INFORMATION

Name: _______________________________________

Relationship to Patient: ________________________

DOB: ____ /____ /____ SS# ______ - _____ - ______

Address: ____________________________________

____

Primary Phone Number: (______) ______-________

☐ Home ☐ Work ☐ Cell

Secondary Phone Number: (______) ______-________

☐ Home ☐ Work ☐ Cell

Email: _______________________________________

Employer: ____________________________________

DAD'S INFORMATION

Name: _______________________________________

Relationship to Patient: ________________________

DOB: ____ /____ /____ SS# ______ - _____ - ______

Address: ____________________________________

____

Primary Phone Number: (______) ______-________

☐ Home ☐ Work ☐ Cell

Secondary Phone Number: (______) ______-________

☐ Home ☐ Work ☐ Cell

Email: _______________________________________

Employer: ____________________________________

Contact outside of home: ____

Relation to patient: ____ Phone Number: (______) ______-________

Primary Insurance Name: ________________________________ Subscriber's Name: ___________________________

Secondary Insurance Name: ______________________________ Subscriber's Name: ___________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Birth & Beyond Pediatrics, P.C. to furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for medical services rendered to my child. I understand that I am ultimately responsible for any amounts not covered by insurance. I further authorize a copy of this authorization to be used in place of original.

Signature of Parent/Legal Guardian: ____ Date: ____ /____ /____

CONFIRMATION OF APPOINTMENTS VIA TEXTING

I hereby authorize Birth & Beyond Pediatrics, P.C. to notify me of my child's appointment(s) via texting. I am aware my child's name and time of appointment will appear on the text. The cell phone number to use for texting is:
(______) ______-________

Signature of Parent/Legal Guardian: ____ Date: ____ /____ /____