WOODBRIDGE PEDIATRICS
UPDATED INFORMATION FORM

Patient_____ Sex: □M □F DOB:____/____/___Chart#_____

Primary Email address_____

Preferred Pharmacy: Name, location and phone #:_____

Mother/Guardian_____SS#_____ DOB:____/____/____

Address_____ Home #:_____
City/State/Zip_____ Cell # _____
Employer_____ Work #:_____

Father/Guardian_____SS#_____ DOB:____/____/____

Address_____ Home #:_____
City/State/Zip_____ Cell # _____
Employer_____ Work #:_____

*Sibling*_____ Sex: □ M □ F DOB:____/____/____
*Sibling*_____ Sex: □ M □ F DOB:____/____/____
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*Sibling*_____ Sex: □ M □ F DOB:____/____/____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

I AUTHORIZE WOODBRIDGE PEDIATRICS TO TREAT MY CHILD. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF INSURANCE FORMS. I AUTHORIZE PAYMENT DIRECTLY TO WOODBRIDGE PEDIATRICS, LTD., FOR ALL MEDICAL OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE. I ALSO AUTHORIZE THE RELEASE OF MEDICATION HISTORY FOR E-PRESCRIBING TO MY PREFERRED PHARMACY. I GIVE PERMISSION FOR MY PROVIDER TO VIEW MY CHILD'S PRESCRIPTION HISTORY FROM EXTERNAL SOURCES.

I AUTHORIZE MY HEALTH CARE PROVIDER TO USE AN AUTOMATED TELEPHONE SYSTEM AND/OR E-MAIL AND TO USE MY NAME, ADDRESS, AND PHONE NUMBER TO LEAVE A MESSAGE WITH LIMITED PROTECTED HEALTH / APPOINTMENT INFORMATION. I ALSO AUTHORIZE MY HEALTHCARE PROVIDER TO DISCLOSE TO THIRD PARTIES WHO ANSWER MY PHONE LIMITED PROTECTED HEALTH INFORMATION REGARDING PENDING APPOINTMENTS, AND TO LEAVE A REMINDER MESSAGE ON MY VOICE MAIL SYSTEM AND ANSWERING MACHINE.

I UNDERSTAND THAT I AM 18 YEARS OF AGE OR OLDER AND FINANCIALLY RESPONSIBLE FOR ALL CHARGES, CO-PAYMENTS AND ANY CHARGES NOT PAID BY MY INSURANCE.

PARENT/GUARDIAN'S (PERSON RESPONSIBLE FOR PAYMENT)

SIGNATURE:_____**DATE:**_____