Date:______/________/____________

Ada Pediatrics

650 N. Cole Rd. Boise, ID 83704
P: (208)323-1222 F: (208)323-1825

Family Information Sheet

☐ Phone Change ☐ Address Change ☐ Name Change

☐ **Mother** ☐ **Father** ☐ **Other:**____________	☐ **Mother** ☐ **Father** ☐ **Other:**______________
Name______________________________	Name______________________________
Address____________________________	Address____________________________
City________State________ Zip____________	City______________State______Zip__________
DOB______________Phone:______________	DOB______________Phone:________________
SSN_______________________________	SSN________________________________
Email ______________________________	Email_______________________________
Employer___________________________	Employer ___________________________

Preferred Provider (Please Circle One): Dr. Bob Lindsay Dr. Ryan Lindsay
Preferred Appointment Reminder (Please Circle One): Text / Call Primary Number :(_____)_______-___________

Children (Please list oldest to youngest, more space provided on back)

Name:____Sex:________________________
First *M* *Last*
DOB:______________ Primary Insurance:_____________________ Secondary Insurance:______________________
Medicaid Number:____

Name:____Sex:________________________
First *M* *Last*
DOB:______________ Primary Insurance:_____________________ Secondary Insurance:______________________
Medicaid Number:____

Name:____Sex:________________________
First *M* *Last*
DOB:______________ Primary Insurance:_____________________ Secondary Insurance:______________________
Medicaid Number:____

Name:____Sex:________________________
First *M* *Last*
DOB:______________ Primary Insurance:_____________________ Secondary Insurance:______________________
Medicaid Number:____

Primary Insurance Information (Please give your insurance card to the Receptionist)

Name of Carrier: ____________________Policy Holder: ______________________Policy Holder DOB:_____________

Policy Number: _____________________________ Group Number: _________________________Co-Pay:_________
Are all family members covered? Y / N If not, specify those not covered:_____________________________________

Secondary Insurance Information (Please give your insurance card to the Receptionist)

Name of Carrier: ____________________Policy Holder: ______________________Policy Holder DOB: ____________
Policy Number: ______________________________________ Group Number: _______________________________
Are all family members covered? Y / N If not, specify those not covered:_____________________________________

Office staff/system update completed by____ Date___________________

Ada Pediatrics

650 N. Cole Rd. Boise, ID 83704
P: (208)323-1222 F: (208)323-1825

Emergency Contact (List additional persons who may bring children for appointments or who we are authorized to communicate with for medical information)

Name: ______________________________ Phone: ______________________________
Relationship to Patient(s): ______________________________

Name: ______________________________ Phone: ______________________________
Relationship to Patient(s): ______________________________

Additional Children

Name: ______________________________ Sex: ______________
First M Last
DOB: __________ Primary Insurance: ______________ Secondary Insurance: ______________
Medicaid Number: ______________________________

Name: ______________________________ Sex: ______________
First M Last
DOB: __________ Primary Insurance: ______________ Secondary Insurance: ______________
Medicaid Number: ______________________________

Name: ______________________________ Sex: ______________
First M Last
DOB: __________ Primary Insurance: ______________ Secondary Insurance: ______________
Medicaid Number: ______________________________

Name: ______________________________ Sex: ______________
First M Last
DOB: __________ Primary Insurance: ______________ Secondary Insurance: ______________
Medicaid Number: ______________________________

Name: ______________________________ Sex: ______________
First M Last
DOB: __________ Primary Insurance: ______________ Secondary Insurance: ______________
Medicaid Number: ______________________________

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

- I understand that I am financially responsible for all professional charges that my children may incur.
- All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.
- I hereby authorize payment of medical benefits direct to Advanced Pediatric Associates. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations.
- Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to Ada Pediatrics to treat my child in their office as required by the events of that emergency situation.
- Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for Ada Pediatrics

______________________________ ______________________________ __________
Parent/Guardian Signature (Patient Signature if 18 or older) Printed Name Date

Office staff/system update completed by______________________________ **Date**______________