Pediatrics at Cherry Creek
300 South Jackson Street, Suite 300
Denver, CO 80209
voice: (303) 377-9663 fax: (303) 377-9954

Pediatrics at Stapleton Plaza
3401 Quebec Street, Suite 3900
Denver, CO 80207
voice: (303) 388-4333 fax: (303) 388-4777

PATIENT INTAKE FORM

PATIENT INFORMATION:

Please complete one form per child.

Patient's/Child's Name: _____
First *MI* *Last* *Nickname*

Home Address: _____
Street Address *City* *Zip Code* *Home Phone*

Date of Birth: ____ / ____ / ____ (Month / Day / Year)

Gender: ☐ Male ☐ Female

☐ American Indian/Alaska Native

HOUSEHOLD INFORMATION:

MOTHER Lives with Mother? Yes No

Name: _____
First *MI* *Last*

Date of Birth: ____ / ____ / ____
Month *Day* *Year*

Phone _____
Work *Cell*

Employer: _____

Social Security #_____

Email: _____

FATHER Lives with Father? Yes No

Name: _____
First *MI* *Last*

Date of Birth: ____ / ____ / ____
Month *Day* *Year*

Phone _____
Work *Cell*

Employer: _____

Social Security #_____

Email: _____

Please list all those living in the child's home.

Name	Relationship to child	Birthdate	Health Problems

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

_____

If one or both parents are not living in the home, how often does child see the parent/parents not in home?

_____

TREATMENT CONSENT:

PLEASE LIST THE PERSON(S) THAT YOU AUTHORIZE TO ACCOMPANY AND GIVE CONSENT FOR TREATMENT TO THE CHILD AT APPOINTMENT TIME, OTHER THAN PARENT.

Name	*Home Phone*	*Work Phone*	*Relationship to patient*
Name	*Home Phone*	*Work Phone*	*Relationship to patient*

➢ _____

Signature of Parent/Legal Guardian of Minor Date

Pediatrics at Cherry Creek
Pediatrics at Stapleton Plaza

Patient's Name _____

Date of Birth _____

Notice of Privacy Practices:

I, _____, have reviewed a copy of Pediatrics at Cherry Creek's /Pediatrics at Stapleton Plaza's notice of privacy practices. (Located at the front desk.)

_____ _____

➢Signature of parent/legal guardian Date

HIPAA Authorizations

By signing below, I authorize Pediatrics at Cherry Creek/Pediatrics at Stapleton Plaza to use and/or disclose certain protected health information (PHI) about my child for the purposes indicated below. I do not have to sign this authorization in order to have my child receive treatment from Pediatrics at Cherry Creek/Pediatrics at Stapleton Plaza. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

School/Camp/Daycare physical forms: Do you authorize Pediatrics at Cherry Creek/Stapleton Plaza to complete and forward school/camp/daycare forms to the appropriate entity? ☐ Yes ☐ No Initials _____

Communications: Do you authorize Pediatrics at Cherry Creek/Stapleton Plaza to leave information regarding your child on your home answering machine? ☐ Yes ☐ No Initials _____

Cell Phone Voice Mail? ☐ Yes ☐ No Initials _____ Email: ☐ Yes ☐ No Initials _____

➢Signature of parent/legal guardian _____ Date _____

Financial Responsibility / Insurance: *(Must be filled out and signed)*

Person Responsible for Account:

_____

First *Last* *Relationship*

Home Address: Employer: _____

_____ _____

Street Address *City* *ST* *Zip* *Street Address* *City* *ST* *Zip*

Primary Insurance Co: _____ Secondary Insurance Co: _____

Company Name *Company Name*

_____ _____

Claims Address *City* *ST* *Zip* *Claims Address* *City* *ST* *Zip*

_____ _____

Member/Subscriber # *Group/Plan #* *Member/Subscriber #* *Group/Plan #*

I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release the minimum necessary information needed to secure the payment of benefits.

I also understand that any changes to my insurance coverage or contact information will be reported to Pediatrics at Cherry Creek/Pediatrics at Stapleton Plaza within 30 days of effective date. I agree that I will pay my outstanding balances (including deductibles, copays, etc.) within 30 days of receipt or risk dismissal and/or having my account sent to a collections agency (balance + 25% in fees).

➢

_____ _____

Signature of parent/legal guardian Date