

PATIENT INFORMATION FORMS

Referred by: Website Friend/Family OBGYN Insurance Walk-In:

PATIENT'S INFORMATION

Name: Last First MI

- Race/Ethnicity: Caucasian, Asian, Native Hawaiian, Hispanic/Latin, American Indian/Alaskan Native, Pacific Islander, African American, E-Other

Date of Birth Gender: M F

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PATIENT COMMUNICATION SETTINGS

- Preferred Language: English, Spanish, Other; Enable: Voice, SMS/Text, Email; Preferred Time to Call: Morning, Afternoon, Evening; Type of Reminders: All, Appointments, Lab/DI Results, Health Maintenance, Rx Confirmation, General Notification; Preferred Phone #; Preferred Email:

INSURANCE INFORMATION

Primary Insurance Company: Name of Person Insured: Policyholder's DOB Gender: M F SSN # Employer: Patient Relationship: Self, Child, Stepchild, Spouse, Other Employer Phone: Policy ID# Group # Group Name

Secondary Insurance Company: Name of Person Insured: Policyholder's DOB Gender: M F SSN # Employer: Patient Relationship: Self, Child, Stepchild, Spouse, Other Employer Phone: Policy ID# Group # Group Name

MOTHER'S OR GUARDIAN INFORMATION

Last Name: Marital Status: Single, Married, Divorced, Widowed, Separated Address: City: State: Zip: Date of Birth Gender: M F Soc. Sec. # Language: English, Spanish, Other Home Phone: Cell Phone: Email Address:

FATHER'S OR GUARDIAN INFORMATION

Last Name: Marital Status: Single, Married, Divorced, Widowed, Separated Address: City: State: Zip: Date of Birth Gender: M F Soc. Sec. # Language: English, Spanish, Other Home Phone: Cell Phone: Email Address:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

Name of Closest Relative Not Living with You: _____

Relationship to Patient: _____ Phone #: _____

CONSENT TO TREAT

I Hereby authorized NPS to provide such medical services necessary, either regular or emergency, as may be determined to be in the best interest of the patient, who is a minor. This authorization shall continue and be in full force and effect until revoked in writing by me.

The following individuals and/ or agencies are hereby authorized to accept and sign treatment for and on behalf of my minor child.

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

Signature of Parent/Legal Guardian or Representative

Date

PHARMACY OF CHOICE

For your convenience, NPS has the ability to submit your prescriptions via electronic prescribing or if you prefer, we can provide you with a paper prescription.

Name of Pharmacy: _____ Telephone #: _____

Address or Cross Streets: _____

I hereby authorize the above pharmacy to transmit information through electronic prescribing. This authorization shall continue and be in full force and effect until revoked in writing by me.

Signature of Parent/Legal Guardian or Representative

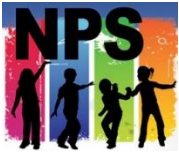
Date

PHARMACY OF CHOICE

I hereby consent to NPS retrieving my prescription history from external sources. This authorization shall continue and be in full force and effect until revoked in writing by me.

Signature of Parent/Legal Guardian or Representative

Date



Nevada Pediatric Specialists
 3201 S. Maryland Parkway suite 608
 Las Vegas, NV 89109
 Phone:702-457-5437
 Fax:702-464-5801

Authorization for Release of Medical Records

PATIENT INFORMATION (Please Print)

Patient's Full Name: _____ **DOB:** _____

Patient's Full Name: _____ **DOB:** _____

Patient's Full Name: _____ **DOB:** _____

Parent/Guardian Name: _____ Phone # _____

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

From:

Physician's Name: _____

Name of Practice: _____

Practice Phone # _____ Practice Fax # _____

To:

Nevada Pediatric Specialists
 3201 S. Maryland Parkway suite 608
 Las Vegas, NV 89109
 Phone:702-457-5437
 Fax:702-464-5801

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory and diagnostic test.

By my signature, I authorize the release of all medical records, I understand and accept the terms of the authorization to release my protected health information (PHI)

 Signature of Parent/Legal Guardian or Representative

 Date