State of Franklin HEALTHCARE ASSOCIATES™

Riverside Pediatrics

Patient's Legal First Name _____ M.I. _____ Patient's Legal Last Name _____

Patient's Birthdate _____ Patient's Social Security Number _____ Patient's Email Address _____ M/F

Patient's Address _____ City _____ State _____ Zip _____

Home Telephone Number _____ Patient's Cell Phone Number _____ Patient's Place of Employment (if applicable) _____

Mother's Full Name _____ Mother's Address (if different from patient) _____ Mother's Cell Phone _____

Mother's SS# _____ Mother's DOB _____ Mother's Place of Employment _____ Mother's Email Address _____

Father's Full Name _____ Father's Address (if different from patient) _____ Father's Cell Phone _____

Father's SS# _____ Father's DOB _____ Father's Place of Employment _____ Father's Email Address _____

Are there any Custody, Guardianship, Adoption, or any other legal documents related to this patient that Riverside Pediatrics would need to have on file? YES / NO:__ If YES please present documents at first appointment.

Please list anyone else living in the home and their relation to the patient.

_____

_____

Date _____ Signature of Patient's Legal Guardian _____

State of Franklin OB/GYN Specialists
Johnson City Internal Medicine Associates
Johnson City Pediatrics
FirstChoice Family Practice
FirstChoice Internal Medicine
FirstChoice Pediatrics
Family Physicians of Johnson City
Blue Ridge Family Medicine

State of Franklin Healthcare Associates

Pinnacle Family Medicine
First Medical OB/GYN
Riverside Pediatrics
SoFHA Central Laboratory
SoFHA Physical Therapy
SoFHA Sleep Center
SoFHA Walk-In Clinic
SoFHA Clinical Research

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected medical information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

	Name	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Emergency Contact Number other than YOUR home phone number:

Name: _____ Phone Number: _____

By signing below, I agree to the fore mentioned statements.

_____ _____
Patient or Guardian Date

_____ _____
Practice Representative Date

Patient Name: _____ Account Number: _____

Consent to Treatment of a Child by Authorized Persons

The undersigned parent or legal guardian of _____ _____ authorizes the person(s) listed below to
(Child's Name) (DOB)
consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____ Relationship to Child: _____ Phone: _____

   Name: _____ Relationship to Child: _____ Phone: _____

   Name: _____ Relationship to Child: _____ Phone: _____

2. Medical concerns: _____
3. Known allergies: _____

Name of Parent or Legal Guardian: _____ Relationship to Child: _____
(Print Name)

Contact Number(s): _____

Address: _____ City, State, Zip: _____

Signature: _____ Date: _____

This consent is effective until withdrawn in writing by the child's parent or guardian.

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