HERSHEY PEDIATRIC CENTER

441 E. Chocolate Ave
Hershey, PA 17033
717-533-7850 Fax 717-533-8294

PATIENTS:

First Name: _____ Last Name: _____ Male/Female, Birth Date: ____/____/____

First Name: _____ Last Name: _____ Male/Female, Birth Date: ____/____/____

First Name: _____ Last Name: _____ Male/Female, Birth Date: ____/____/____

First Name: _____ Last Name: _____ Male/Female, Birth Date: ____/____/____

HOME ADDRESS: **HOME PHONE NUMBER:**

_____

PARENTS/GUARDIANS

Father: _____ DOB: ____/____/_____ Employer: _____

Cellphone: _____ Email: _____

Mother: _____ DOB: ____/____/_____ Employer: _____

Cellphone: _____ Email: _____

PRIMARY INSURANCE:

Policyholder's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Employer's Name: _____ Work Phone #: _____

Insurance Company: _____

Insurance ID #: _____ Group #:_____

Who *if* anyone other than the parents or legal guardian has permission to access your child's medical records and obtain results for lab tests including bringing your child to Hershey Pediatric Center without your presence and making medical decisions for his or her treatment.

☐ N/A ☐ YES, the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I release Hershey Pediatric Center, its employees and clinicians from all liability for any adverse results caused by my authority to treat, release and discuss with the above individual(s) pertaining to my child's care and medical records. I authorize Hershey Pediatric Center to release any medical information necessary to process insurance claims for myself, my child (ren) and request the insurance company to make payment to Hershey Pediatric Center.

PARENT/LEGAL GUARDIAN: _____DATE: _____