# Pediatric Associates, PA Patient Information Sheet

| | |
|---|---|
| Date: | |
| Patient Name: | |
| Patient Address: | |
| City: | State/Zip: |
| Home #: | Cell #: |
| Patient SS #: | Patient DOB: |
| Patient Email Address: | |

| Race | | Languages Spoken | | Ethnicity | |
|---|---|---|---|---|---|
| Alaskan Native | | ASL | | Hispanic/Latino | |
| Native American | | Arabic | | Not Hispanic/Latino | |
| Asian | | Chinese | | | |
| Black/African American | | English | | | |
| Hawaiian | | Hindi | | | |
| Pacific Islander | | Korean | | | |
| White | | Spanish | | | |
| More than one | | Other | | | |

List the persons authorized to access your medical records:

| | |
|---|---|
| Name : | Relationship: |
| Name : | Relationship: |

| | |
|---|---|
| Emergency Contact: | |
| Home #: | Cell #: |
| Emergency Contact: | |
| Home #: | Cell #: |

By signing below, I authorize, acknowledge, and agree to the following:

* I agree to have Pediatric Associates, PA render the services needed to provide me with the appropriate medical treatment.

* I understand that I have the right to read the Notice of Privacy Practices before signing this agreement.

* If I ask, Pediatric Associates, PA will provide me with the most recent copy of their Notice of Privacy Practices.

* I have received a copy of Pediatric Associates, PA's Notification of Responsible Party.

Signature: