H. Brian Leeper, M.D.
Charles A. Moss III, M.D.
M. Andy Lee, M.D.

Bram I. Pinkley, M.D.
David J. White, M.D.
Christina M. Lohse, M.D.

BRENTWOOD CHILDREN'S CLINIC

Patient Demographics

Patient SS# _____Patient Date of Birth _____ Patient Sex: _____

PATIENT'S FULL NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____ PLACE OF BIRTH: _____
(Hospital)

HOME PHONE (_____)-_____-_____ CELL PHONE (_____)-_____-_____

PARENT/LEGAL GUARDIAN: _____

FATHER'S NAME _____

ADDRESS _____

_____

_____

EMPLOYER: _____

PHONE NUMBERS: _____

_____

SSN#: _____

DOB: _____

MOTHER'S NAME_____

ADDRESS _____

_____

_____

EMPLOYER: _____

PHONE NUMBERS: _____

_____

SSN#: _____

DOB: _____

PRIMARY INS: _____ SECONDARY INS: _____

NAMES AND DOB OF OTHER CHILDREN IN FAMILY: _____

_____

IN CASE OF AN EMERGENCY, WHO MAY WE CONTACT OTHER THAN YOUR SPOUSE?

NAME:_____PHONE NUMBER:_____

NAME:_____PHONE NUMBER:_____

PARENT'S EMAIL ADDRESS: _____

CONSENT FOR TREATMENT:
This is to certify that I, the parent/legal guardian, request treatment of my minor child by the physicians and/or staff of Brentwood Childrens Clinic. Authorization is hereby granted for such treatment.

Parent/Legal Guardian Signature _____Date_____

Witness Signature: _____Date_____

INFECTION CONTROL CONSENT

To protect employees against possible transmission of blood borne disease, such as hepatitis B human Immunodeficiency Virus (HIV), by signing below I understand it may be necessary for my child's blood to be tested if any employee is exposed by needle stick or any other method of exposure. The results are confidential and the testing is at no cost to the patient or responsible party.

INSURANCE BENEFIT ASSIGNMENT

As a courtesy to our patients, we will file your insurance if you are covered under a plan that we participate with. By singing below, I hereby assign insurance benefits to Brentwood Childrens Clinic, PC. I also authorize BCC to release any information necessary for payment of the claim to my insurance carrier at their request. I also understand that I am fully responsible for payment of this account if my insurance information is incorrect or if my insurance doses not pay in a timely manner.

PAYMENT OF ACCOUNT

As stated above, payment is due at the time of service. **All deductible, co-insurances, and co-pays are to be paid at the time of service.** Please make checks payable to Brentwood Childrens Clinic, PC. Your child's health is important to us. If you encounter a hardship in payment of your account, please call our billing department at (615)-261-1214. We will attempt to make payment arrangements so there is no interruption in your child's health care or well visits. If your account becomes past due, we will send your account to collections. If your account goes to court, you will be responsible for all court cost and attorney fees. By signing below, I am stating that I understand the payment policies of Brentwood Childrens Clinic.

NOTICE OF PRIVACY POLICIES

I have received a copy of the Brentwood Childrens Clinic, PC *Notice of Privacy Policies* and have been given an opportunity to review this document. I understand Brentwood Childrens Clinic, PC has the right to change its *Notice of Privacy Policies* from time to time and that I may contact Brentwood Childrens Clinic, PC at any time to obtain a current copy of the *Notice of Privacy Policies*.

PLEASE LIST ALL CHILDREN WHO ARE PATIENTS AT BRENTWOOD CHILDRENS CLINIC

CHILD'S FULL NAME	DATE OF BIRTH
CHILD'S FULL NAME	DATE OF BIRTH
CHILD'S FULL NAME	DATE OF BIRTH
CHILD'S FULL NAME	DATE OF BIRTH
CHILD'S FULL NAME	DATE OF BIRTH

PARENT/GUARDIAN	DATE	WITNESS