# Annual Update Sheet

Child's Name: ____________________________ DOB: _________ M / F SS#:________________________

Child's Name: ____________________________ DOB: _________ M / F SS#: _______________________

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**Ethnicity:** ◯ Non-hispanic ◯ Hispanic **Race(s):** ◯ African American ◯ Asian ◯ Caucasian ◯Native American ◯ Pacific Islander ◯ Other ◯Refused

**Preferred language:** __________________________

Address: __________________________________ Apt #: ______ City: _____________ Zip: ___________

Primary Phone: ________________________ ◯Home ◯Cell Secondary Phone: _________________________ ◯Home ◯Cell

Email: ___________________________________________

Primary Ins: ___________________________Member ID: _____________________ Grp #: ___________

Subscriber's Name: ______________________________ SS#: __________________DOB: ___________

Secondary Ins: ________________________ Member ID: _____________________ Grp #: ____________

Subscriber's Name: ______________________________ SS#: __________________DOB: ___________

**How would you like to receive communications from us:** Text Email Phone call

We will never share your email address with anyone. Your protected health information will never be disclosed in the email communications and full HIPAA/HITECH guidelines will always be observed

## Treatment Authorization

I authorize the following people to bring my child(ren) to Wee Care Pediatrics for medical care and treatment. I understand that I may revoke this authorization at any time and it will remain in effect until I do so. *If you choose not to authorize any other person(s), please write N/A.

__________________________________ __________________________________
(Name) (Relationship to child)

__________________________________ __________________________________
(Name) (Relationship to child)

I understand that I am responsible for updating my insurance, address or contact information with Wee Care Pediatrics. I understand that account balances, copay and deductibles are due at the time of service. Any account balances that exceed 90 days will be sent to an outside collection agency and I will be responsible for collection and or legal fees. I authorize Wee Care Pediatrics to submit a claim to my health plan on my behalf for payment.

___________________________/___________________________/____________ Date: _________

Print (Parent or Guardian) Signature Relationship