Wee Care Pediatrics
Exceptional People Providing Exceptional Care

OVER THE RAINBOW
PEDIATRIC URGENT CARE & WELLNESS

General information

Patient's name Last: _____ First: _____ MI: _____

Sex: M / F Birthdate: _____/_____/_____ Home Phone #: _____Cell#:_____

Address: _____Apt #: _____ City: _____

State: _____ Zip: _____ Email: _____

Ethnicity: Hispanic/Non-Hispanic **Race:** African American / Asian / Caucasian / Native American

Pacific Islander / Other: _____ / Refuse **Preferred Language:** _____

Does your child have a pediatrician? YES / NO : If yes, please let us know who so we can send over records:

Doctors/practice name: _____Phone number:_____

Mother/Guardian's Name:

Last: _____ First: _____ Birth Date: ____/____/____

SS #: _____Home Phone #: _____Cell Phone #: _____

Address (if different than childs): _____ Apt: _____City: _____ State: _____ Zip:

Employer: _____ Occupation: _____Work Phone #: _____

Father/Guardian's Name:

Last: _____ First: _____ Birth Date: ____/____/____

SS #: _____Home Phone #: _____Cell Phone #: _____

Address (if different than childs): _____ Apt: _____City: _____ State: _____ Zip:

Employer: _____ Occupation: _____Work Phone #: _____

Referral information

How did you hear about Wee Care Pediatrics / Over the Rainbow Pediatric Urgent Care:

- ☐ Obstetrics office // If yes, please state which office: _____
- ☐ Daycare/School // If yes, please state which daycare/school: _____
- ☐ Friend/Family member
- ☐ Google Search/Social Media
- ☐ Other:_____

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Insurance information

Primary ins. : Plan:_____Policy #_____Subscriber:_____DOB:_____

Secondary ins. : Plan:_____Policy #_____Subscriber:_____DOB:_____

Authorization for CONSENT TO TREAT

I have the legal right and responsibility to obtain and consent to medical treatment for this patient. I understand that by signing this form and by bringing this child to this medical office for care, I am giving permission to the doctor and other healthcare providers in this office to provide any necessary treatment to this patient.

Parent/Guardian signature: _____ Date: _____

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

Name of person: _____ Relationship to patient: _____Phone#:_____

Name of person: _____ Relationship to patient: _____Phone#:_____
This delegation shall be valid until I withdraw this delegation of consent.

Parent/Guardian signature: _____ Date: _____

Acknowledgment of Financial Responsibility

I understand that I am financially responsible for services in the office that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Parent/Guardian signature: _____ Date: _____

Acknowledgment of receipt of Privacy Practices

Notice to patients: We are required to make available to you a copy of our notice of Privacy Practices, which states how we may use and/or disclose your health information.
I acknowledge that I have been offered a copy of the OTRPUC's Notice of Privacy Practices.

Parent/Guardian signature: _____ Date: _____