

**DEMOGRAPHICS**

**Child**

<b>Name (as on birth certificate)</b>
<b>Date of birth</b>
<b>Gender</b>
<b>Social Security Number</b>
<b>Language preference (if not English)</b>
<b>Race/Ethnicity</b>
<b>Family preferred method of communication (if not phone)</b>
<b>Please describe any vision or hearing impairment that requires accommodation</b>
<b>Adopted or in foster care?</b>

**Parent(s)/  
Legal  
Guardian(s)  
)**

<b>Name</b>
<b>Social security number</b>
<b>Date of birth</b>
<b>Gender</b>
<b>Street address</b>
<b>City, State, Zip code</b>
<b>Home phone number</b>
<b>Work phone number</b>
<b>Email</b>
<b>Occupation</b>

<b>Name</b>
<b>Social security number</b>
<b>Date of birth</b>
<b>Gender</b>
<b>Address</b>
<b>Home phone number</b>
<b>Work phone number</b>
<b>Email</b>
<b>Occupation</b>

**Subscriber**

<b>Name of person who holds insurance plan</b>
--

**Emergency  
Contact**

(other than  
parent/guardian)

<b>Name</b>
<b>Relationship to child</b>
<b>Address</b>
<b>Phone number</b>

**Sibling(s)**

	<b>Name</b>	<b>Date of Birth</b>	<b>Gender</b>
1.			
2.			
3.			
4.			
5.			





**Lower Bucks Pediatrics, P.C.**

**1690 Big Oak Road  
Yardley, PA 19067**

**Telephone (215) 493-1750  
Fax (215) 493-1470**

Web: [www.lowerbuckspediatrics.com](http://www.lowerbuckspediatrics.com)  
Email: [info@lowerbuckspediatrics.com](mailto:info@lowerbuckspediatrics.com)

**PATIENT/PARENT/GUARDIAN RELEASE**

PATIENT NAME: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

THE ABOVE NAMED PATIENT IS MY (circle one):

**SON          DAUGHTER          SELF          FOSTER CHILD          OTHER: \_\_\_\_\_**

I certify the demographic and insurance information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I acknowledge that interest or fees, including collections and legal fees, at the provider's current rate, may be charged on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

SIGNED (if not the patient, I also certify that I am parent/legal guardian of the patient):

\_\_\_\_\_  
DATE: \_\_\_\_\_



**Lower Bucks Pediatrics, P.C.**

**1690 Big Oak Road  
Yardley, PA 19067**

**Telephone (215) 493-1750  
Fax (215) 493-1470**

Web: [www.lowerbuckspediatrics.com](http://www.lowerbuckspediatrics.com)  
Email: [info@lowerbuckspediatrics.com](mailto:info@lowerbuckspediatrics.com)

EXHIBIT 4

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have been offered a copy of Lower Bucks

(Patient/Legal Guardian Name)

Pediatrics' Notice of Privacy Practices and have received a copy if so requested.

(A copy is available in each waiting room).

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient/Legal Guardian

Date