Bee Well PEDIATRICS

PATIENT INFORMATION

NAME (Last, First): _____

ADDRESS: _____

DATE OF BIRTH: _____ / _____ / _____

SS#:_____ SEX *(circle one)*: M F

PLEASE LIST ANY OTHER DOCTORS YOUR CHILD SEES (NAME/SPECIALTY):

_____

_____

_____

E-MAIL *(We will NOT give this information out)*: _____

PHONE: HOME _____ WORK _____ CELL _____

Who may we thank for referring you your child to us? _____

EMERGENCY CONTACT(S):

NAME (Last, First): _____ RELATIONSHIP: _____

PHONE: HOME _____ WORK _____ CELL _____

NAME (Last, First): _____ RELATIONSHIP: _____

PHONE: HOME _____ WORK _____ CELL _____

EMPLOYMENT INFORMATION:

COMPANY: _____

ADDRESS: _____

PHONE: _____

Bee Well PEDIATRICS

INSURED PERSON

NAME (Last, First): _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

DATE OF BIRTH: _____ / _____ / _____ SS#: _____ - _____ - _____

INSURANCE CARRIER: _____

POLICY NUMBER: _____

Bee Well PEDIATRICS of Central Texas – OFFICE POLICIES

In order to continue to serve our valued patients we have adopted the following policies:

1. **CANCELLATIONS:** We require at least a 24 hour notice for cancellation of appointments so that we may offer your appointment time to another patient. If you do not provide at least a 24 hour notice, you will receive a bill for the $50 no-show fee.

2. **TARDINESS:** If you are 15 minutes late or more, you may be rescheduled in order to accommodate our other patients' appointment slots

3. **PRESCRIPTION REFILLS:** Refill requests must be made at least **one week in advance** and should be faxed from your pharmacy to our office (512-225-0770) or requested through our online patient portal at www.beewellaustin.com. This reduces medication errors from phone messages.

4. **AFTER-HOURS CALLS**: After-hours calls will be answered by our answering service, Med Exchange. If necessary, they may page the on-call the physician. Please make prescription refill and appointment requests during office hours or through our online patient portal at www.beewellaustin.com. See #3 above.

5. **MEDICAL RECORDS**: There is a $25.00 fee for release of medical records. This must be paid prior to the release of records and helps cover the cost of printing and shipping. Please allow one week to process your request.

6. **PET THERAPY**: We are proud to offer pet therapy services to our patients; however, we realize that not all children enjoy animals, especially dogs. If your child is allergic to, or uncomfortable with dogs, please let our staff know PRIOR to your visit so that we can make sure your time with us is as pleasant and stress-free as possible for our young patients.

I have read and understand the policies set by **Bee Well PEDIATRICS of Central Texas**
and I agree to the terms.

_____	_____	_____
(PLEASE PRINT YOUR NAME)	(PLEASE SIGN YOUR NAME)	DATE

_____
RELATIONSHIP TO PATIENT