Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Name: ______________________________ **Sex: M**_______ **F**______ **DOB:** ________________

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Patient's Name: ______________________________ **Sex: M**_______ **F**______ **DOB:** ________________

Patient's Name: ______________________________ **Sex: M**_______ **F**______ **DOB:** ________________

Patient's Home Address: ______________________________ **Home Phone: (____) _______-__________**

Street City ST Zip Code

Marital Status of Child's Parents (please check one):

PARENT'S INFORMATION

Married ________ Single________ Separated________ Divorced________

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Mother's Name: ______________________________ Date of Birth: ___________________

Same as above ☐ Home Address: ______________________________

Street City ST Zip Code

Cell: ______________________________ Email: ______________________________

Employer: ______________________________ SSN# ______________________________

Please Circle (Natural, Step, Adoptive Parent, Guardian)

Father's Name: ______________________________ Date of Birth: ___________________

Same as above ☐ Home Address: ______________________________

Street City ST Zip Code

Cell: ______________________________ Email: ______________________________

Employer: ______________________________ SSN# ______________________________

INSURANCE INFORMATION

Primary Insurance Company Name:	Name of Policy Holder	Policy/ID Number	Group Number
Primary Insurance Company Name:	Name of Policy Holder	Policy/ID Number	Group Number

Emergency Contact (Not living with you): Name: ______________________________ Phone: (____) _______-____________

How did you hear about our practice? ______________________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly from my insurance company to the physicians of Great Destinations Pediatrics for Medical treatment(s) provided to my child.

I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney fees, and all other costs.

I hereby authorize GDP to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and health care operations of my child.

FINANCIAL/OFFICE POLICY & HIPAA:

I have read and understand the foregoing financial and office policy and agree to abide by the terms of this office policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, including Omnibus Rule.

______________________________ _______/_________/_________

Responsible Party Printed Name Date

______________________________ ______________________________

Responsible Party Signature *Relationship to Patient(s)*

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