

Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Name _____	Sex M ___ F ___	Date of Birth _____
Patient's Home Address _____		Home Phone(____)-____-____
Street	City	ST Zip

Marital status of child's parents (Please Check One):

Married ___ Single ___ Separated ___ Divorced ___

PARENT'S INFORMATION

Please Circle (Natural, Step, Guardian)			
Mother's Name _____	(Maiden Name) _____	SS# _____	-____-____
Home Address _____		Home Phone(____)-____-____	
Street	City	ST	Zip
Employer _____	Cell or Work (____)-____-____	Email _____	
Occupation _____	Date of Birth _____		
Please Circle (Natural, Step, Guardian)			
Father's Name _____	SS # _____	-____-	-____
Home Address _____		Home Phone(____)-____-____	
Street	City	ST	Zip
Employer _____	Cell or Work (____)-____-____	Email _____	
Occupation _____	Date of Birth _____		

INSURANCE INFORMATION

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

Other Children in our Practice: Name _____ DOB _____ Sex: M ___ F ___

Name _____ DOB _____ Sex: M ___ F ___

Name _____ DOB _____ Sex: M ___ F ___

Name _____ DOB _____ Sex: M ___ F ___

Name of Nearest Relative: Name _____ Phone _____

(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 physician's of Great Destinations Pediatrics (GDP) 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 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, copays, 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's 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 policy. I also acknowledge that I have received a copy of the notice of Privacy Practices.

Date ____/____/____

Responsible Party Signature