

Great Destinations Pediatrics P.C.

PATIENT'S INFORMATION

Patient's Name: _____	Sex: M _____ F _____	DOB: _____
Patient's Name: _____	Sex: M _____ F _____	DOB: _____
Patient's Name: _____	Sex: M _____ F _____	DOB: _____
Patient's Name: _____	Sex: M _____ F _____	DOB: _____
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: _____ **Maiden 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? _____ If doctor, please name: _____

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)