Growing Kids Pediatrics, LLC

PATIENT INFORMATION SHEET

Please print clearly and complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (First, M.I., Last): ______________________________ Home Telephone: (________) ______________________

Address: ______________________________ Mother's Name: ______________________________
First Last DOB

City/State/Zip: ______________________________ Cell Number: (_______) ______________________

Social Security #: ______________________________ Father's Name: ______________________________
First Last DOB

Sex: ☐ Male ☐ Female Date of Birth: ________________ Cell Number: (_______) ______________________

Emergency Contact/Phone (not living with you) ____
Name Phone Relationship

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Name of Guarantor: ______________________________ Relationship to Patient: ______________________

DOB: ______________ Social Security # __________________ Does patient live with guarantor? ☐ Yes ☐ No

Guarantor's Address: ______________________________ Employer of Guarantor: ______________________

____ Employer Address: ______________________

Employer Phone: (_______) ______________________

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PRIMARY INSURANCE INFORMATION

Insurance Company: ______________________________ Policy Owner: ______________________

Telephone: ______________________________ DOB of Subscriber: ______________________

Policy #: ______________________ Group #: ______________ Address of Policy Owner: ______________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ______________________________

SECONDARY INSURANCE INFORMATION

Insurance Company: ______________________________ Policy Owner: ______________________

Telephone: ______________________________ DOB of Subscriber: ______________________

Policy #: ______________________ Group #: ______________ Address of Policy Owner: ______________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ______________________________

I hereby assign, transfer, and set over to Growing Kids Pediatrics, LLC, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby consent to routine diagnostic procedures and medical treatment provided throughGrowing Kids Pediatrics, LLC, and I understand that no guarantee of results has been made.

Patient's Signature ______________________________________ Date ______________________