



**Patient Information (Confidential)**

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Preferred to be called

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  M  F Best Email address: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work Alternate Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work

Child lives with:  Both Parents  Mom  Dad  other

Medical Guardian/authorization for medical information:  Both Parents  Mom  Dad  other

Please define other: \_\_\_\_\_

**Mother:** \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Same as primary address

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work Alternate Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work

**Father:** \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Same as primary address

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work Alternate Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work

**Guardian:** \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Same as primary address

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work Alternate Phone: (\_\_\_\_) \_\_\_\_\_ Landline/Cell/Work

**Emergency Contact:** \_\_\_\_\_ Phone

**Insurance Information:**

Company/Plan name: \_\_\_\_\_ Insured ID# \_\_\_\_\_ Eff Date: \_\_\_\_\_

Insured Members name: \_\_\_\_\_ Relationship to Pt: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Group# \_\_\_\_\_

It is **YOUR** responsibility to know your insurance benefits. As a courtesy, Pediatrics of Okaloosa will attempt to verify your health insurance benefits, and or necessary authorizations for you. Please be aware, this is only "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. I give Pediatrics of Okaloosa permission to file claims with the above insurance company on my behalf.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_