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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: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work 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: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work Landline/Cell/Work

Father: _____ DOB: _____

Address: _____ City: _____ St: _____ Zip: _____

☐ Same as primary address

Primary Phone: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work Landline/Cell/Work

Guardian: _____ DOB: _____
Relationship to patient

Address: _____ City: _____ St: _____ Zip: _____

☐ Same as primary address

Primary Phone: (____) _____ Alternate Phone: (____) _____
Landline/Cell/Work Landline/Cell/Work

Emergency Contact: _____ - _____
Phone

Insurance Information:

Company/Plan name: _____ Insured ID# _____ Eff Date: _____

Insured Subscribers 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: _____