

Lake Area Pediatrics

Patient Information

(Please Print Clearly)

Patient Name: _____ Date of Birth: _____ Sex Male Female

Social Security#: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Father's Name: _____ Cell Phone: _____ Date of Birth: _____

Social Security#: _____ Employer: _____ Work #: _____

E-Mail Address: _____

Mother's Name: _____ Cell Phone: _____ Date of Birth: _____

Social Security#: _____ Employer: _____ Work #: _____

E-Mail Address: _____

Emergency Contact (other than parent)

Name: _____ Relationship to Patient: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Insurance Information

Insurance information is a necessary part of your child's record. We will strive to direct your care and your need for specialist consults: lab work and tests according to your managed care guidelines. However, our office deals with many different plans and **it is the patient's responsibility to make sure that all facilities and specialists that we refer you to are on your health plan.** Please verify their participation **BEFORE** services are rendered to receive benefits from your insurance company.

Policy Holder: _____ DOB: _____ SS#: _____

Relationship to Patient: _____ Ins. Company: _____

Address (of insurance): _____ Phone: _____

ID#: _____ Group#: _____ Effective Date: _____

To whom may we thank for referring you to Lake Area Pediatrics: _____

Please sign below signifying that you authorize Lake Area Pediatrics to treat the above patient. By signing this you also authorize payment of medical benefits, release of correspondence and/or medical records to other providers involved in your child's care. I have also read and understand the Lake Area Pediatrics Financial Policy.

Signature of Parent or Guardian

Date