Lake Area Pediatrics

Patient Information (Please Print Clearly)

Patient Name:_____ Date of Birth:_____

Sex: __Male __Female Race: _____ Social Security #: _____

Address:_____

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

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

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

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#: _____

Employer:_____ Address:_____ Phone _____

Relationship to Patient:_____ lns. Company: _____

Address (of insurance):_____ Phone: _____

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

ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE

Who 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