

Insurance Information

Primary Policy:

Policy Holder's Name: _____ Birth Date: _____ SSN: ____/____/____ Sex: []M []F

Insurance Carrier: _____ Policy ID#: _____ Group #: _____

Secondary Policy:

Policy Holder's Name: _____ Birth Date: _____ SSN: ____/____/____ Sex: []M []F

Insurance Carrier: _____ Policy ID#: _____ Group #: _____

Additional Contact Questions:

Who should receive billing statements? _____

May all contacts have access to the patient's records electronically? []Y []N

If no, list who may have access _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? []Y []N

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Primary Language: _____ **Ethnicity:** Hispanic / Non-Hispanic / Unknown **Race:** Asian / Black / Hawaiian / White/Unknown

Emergency Contacts (other than parents) Authorized to Bring Patients for Services (Age 21 or over):

(initial if authorized to bring child for services)

1: _____ Relationship _____ Phone: (____) ____ - _____ initial []

2: _____ Relationship _____ Phone: (____) ____ - _____ initial []

3: _____ Relationship _____ Phone: (____) ____ - _____ initial []

4: _____ Relationship _____ Phone: (____) ____ - _____ initial []

5: _____ Relationship _____ Phone: (____) ____ - _____ initial []

I give my permission for medical treatment of the above-named child/children. I also give permission for the initialed authorized individual(s) above to make decisions regarding treatment, prescriptions and immunizations if I am not available to give my consent. I understand that I am financially responsible for non-covered charges. I hereby assign my insurance benefits to be paid directly to the physician and to release any information necessary to process my claim. In the event my account must be placed in collections, I agree to pay collection fee of 30% of account balance. **I have received Gilbert Pediatrics' Privacy Policy, and Financial Policy.**

Completed by (please print): _____

SIGNATURE _____ DATE _____