Rainbow Kids Pediatrics

PATIENT PERSONAL INFORMATION

Name: _____ DOB: _____ ☐ Female ☐ Male

Street: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Parent's Cell (1): _____ Parent's Cell (2): _____

How did you hear about us? _____

PARENT/RESPONSIBLE PARTY INFORMATION

Name: _____ DOB: _____ SS#: _____

Relationship to Patient: _____ Home Phone: _____ Work Phone: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Primary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

SECOND PARENT/SECONDARY INSURANCE INFORMATION Secondary Insurance? ☐ Yes ☐ No

Name: _____ DOB: _____ SS#: _____

Relationship to Patient: _____ Home Phone: _____ Work Phone: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____

Secondary Insurance Company Name: _____

Policy Number: _____ Group Number: _____

EMERGENCY CONTACT INFORMATION

Name of person not living with you: _____

Address: _____ City/State: _____

Home Phone: _____ Work Phone: _____ Zip Code: _____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Rainbow Kids Pediatrics, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Signature: _____

I hereby give lifetime authorization and voluntary consent to Rainbow Kids Pediatrics and its staff to provide basic medical care for diagnosis and treatment which is understood as reasonable by the doctors for current presentation of signs and symptoms.

Date: _____ Signature: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Notice of Privacy Practice.

Date: _____ Signature: _____