BECKER PEDIATRICS

PATIENT INFO:

LAST NAME: _____ FIRST: _____ MI: _____.
DOB: ____/____/____ M—F SOCIAL SECURITY #: _____.

CHILD LIVES WITH : BOTH PARENTS YES—NO **(FILL OUT SECTION A)**

CHILD LIVES WITH : MOM OR DAD (CIRCLE AND **FILL OUT SECTION B)**
WHO HAS CUSTODY ? _____ **(NEED LEGAL PAPERWORK W/CURRENT ID AT APPT)**

IF GRAND PARENTS : A NOTE FROM MOM/DAD (must show current ID at appt)

ARE YOU FOSTER PARENTS : YES—NO (NEED LEGAL PAPERWORK W/CURRENT ID AT APPT)
ARE YOU THE GUARDIANS : YES—NO (NEED LEGAL PAPERWORK W/CURRENT ID AT APPT)
ADDRESS: _____ DOB: ___/___/___ SS # _____ _____
HOME # _____ CELL# _____ EMAIL: _____

NAMES OF SIBLINGS SEEN IN THIS OFFICE:
NAME: _____ NAME: _____.
NAME: _____ NAME: _____.

A—PARENTS INFO: (child lives w/both parents)

MOM LAST NAME: _____ 1ST NAME _____ DOB: ___/___/___ S. EC# _____

DAD LAST NAME: _____ 1ST NAME _____ DOB: ___/___/___ S.SEC# _____
ADDRESS: _____ EMAIL: _____ - _____.
CITY: _____ STATE: _____ ZIP: _____ - HOME # ___ _____
MOMS _CELL#: _____ WORK# _____ DADS CELL _____ WORK# _____:

B—MOMS OR DADS INFO: (PLS HAVE LEGAL PAPERWORK W/CURRENT ID AT APPT)

MOMS FULL NAME: _____ **DOB:** ___/___/___ **SOCIAL SEC#:** _____.
DADS FULL NAME: _____ **DOB:** ___/___/___ **SOCIAL SEC#:** _____
ADDRESS: _____ **EMAIL:** _____
CITY: _____ **STATE:** _____ **ZIP:** _____ **EMAIL:** _____
HOME #: _____ **CELL#:** _____ **WORK#:** _____.

INSURANCE INFORMATION:

RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____.
INSURANCE CO: _____ INS ID#: _____.
GROUP#: _____ COPAY/COINS: _____ DED: _____ HSA/HRA FUND: _____.

EMERGENCY CONTACT: (OTHER THAN PARENTS) NAME: _____ PHONE# _____.
NAMES OF PERSONS AUTHORIZED TO BRING CHILD: (MUST SHOW CURRENT ID AT APPT)

FULL NAME: _____ RELATIONSHIP TO CHILD: _____.
FULL NAME: _____ RELATIONSHIP TO CHILD: _____.
FULL NAME: _____ RELATIONSHIP TO CHILD: _____

PLEASE READ, SIGN, DATE AND RETURN TO RECEPTIONIST:
I/We (parent or legal guardian) do hereby consent to and authorize the performance of all treatments, surgery and medical/behavioral health services by the staff of Becker Pediatrics which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I hereby authorize my insurance benefits to be paid directly to Becker Pediatrics and the release of any information required to process a claim. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

I furthermore agree to pay legal interest, collection expenses and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Becker Pediatrics to release information requested by insurance company and or its representative. I fully understand that the agreement and consent will continue until cancelled by me in writing.

PLEASE SIGN: _____ **PRINT NAME:** _____ **TODAY'S DATE:** ___/___/___.