Dr _____ **Rose City Pediatrics**

Patient's Personal Information

Name_____ [] male [] female DOB _____ SSN#_____-_____-_____

Address _____ Mailing (if different)

_____ _____

_____ _____

Home Phone (____)_____ Medication Allergies _____

Siblings_____

_____

_

Parent #1's Information

Name_____ [] male [] female DOB _____ SSN#_____-_____-_____

Home Address (if different from above) _____

_____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

May we contact you via email? [] yes [] no email: _____

Employer's name _____ Occupation _____

Employer's Street Address _____

Parent #2's Information

Name_____ [] male [] female DOB _____ SSN#_____-_____-_____

Home Address (if different from above) _____

_____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

May we contact you via email? [] yes [] no email: _____

Employer's name _____ Occupation _____

Employer's Street Address _____

Insurance Information (Check One) [] PPO [] EPO [] SELF PAY

Primary Insurance Company

_____

Name of Insured_____ DOB_____ SSN# _____-_____-_____

Policy # _____ Group #_____

Emergency Contact

Name of Person Not Living With You:_____

Relationship:_____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

Assignment of Benefits and Financial Agreement

I hereby give the authorization for payment of insurance benefits to be made directly to Rose City Pediatrics and by 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 collection, and reasonable attorney's fees. I hereby authorize this health care 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.

Signature_____ Date_____