

2010

2010 CENTENNIAL PEDIATRICS
PATIENT INFORMATION FORM

Date:

PATIENT INFO: Last Name: First:

Street Address:

City, State, Zip:

Date of Birth: Age: Male/Female

MOTHER INFO: Last Name: First: SS#

Address: City, State, Zip:

Date of Birth: Marital Status: Employer:

Home Phone: Cell Phone: Other:

FATHER INFO: Last Name: First: SS#

Address: City, State, Zip:

Date of Birth: Marital Status: Employer:

Home Phone: Cell Phone: Other :

Primary Insured: Relationship to Patient:

SS# Ins. Co.: Policy #: Group #

Insurance Claims Address:

Insured's Employer: Employer Phone:

Contact in Case of Emergency(other than parents): Phone:

Sibling Name: Date of Birth: Age:

Sibling Name: Date of Birth: Age:

Sibling Name: Date of Birth: Age:

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE COVERAGE! PLEASE READ THE FOLLOWING CAREFULLY! BY SIGNING BELOW, YOU INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THE FOLLOWING POLICIES:

1. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize the release of medical records for the purpose of medical referrals, and to the persons listed above on this form.
2. I authorize payment of medical benefits from my insurance company or government program to Centennial Pediatrics.
3. I agree to pay all insurance co-pays and/or coinsurance at the time of check-in and prior to services being rendered.
4. I understand that Centennial Pediatrics does not bill secondary insurance.
5. I understand that Centennial Pediatrics does not accept checks.
6. If Centennial Pediatrics cannot verify my insurance at the time of visit, or if I do not bring current proof of insurance to each visit, I agree to pay charges in full before the patient is seen.
7. If any charges incurred by me or my dependents are submitted to a collection agency, I agree to pay all fees including, but not limited to, both the collection agency fee and the account balance.
8. If I miss any appointments without prior notification to this office, I agree to pay a \$25.00 no show charge.
9. I agree to pay a \$25.00 charge, in addition to the check amount, on any of my personal checks which are returned to this office by my bank.
10. While your appointment may be for a specific time, no express or implied guarantee is made that a nurse or physician will see you at that exact time. Centennial Pediatrics makes every effort to see patients in a timely fashion, subject to patient volume and emergencies beyond our control. I agree not to hold Centennial Pediatrics responsible in any manner for time spent waiting to be seen.
11. I understand that Centennial Pediatrics bills insurance as a courtesy. I understand that my financial charges for services rendered by Centennial Pediatrics are ultimately my responsibility.

Responsible Party (Print): _____ Sign: _____ Date: _____