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Pediatric Patient Information

Patient's Last Name: _____ First Name: _____ M: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Date of Birth: _____ Age: _____ Gender: F M

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Mark if they are the same

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

We would like to scan your insurance card at your first visit so please bring it with you to the appointment.

Primary Ins. Company Name: _____ Policy Number: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

Parent 1:

Name: _____ DOB: _____ Relationship to patient: _____

Address: (skip if same) _____ City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

Parent 2:

Name: _____ DOB: _____ Relationship to patient: _____

Address: (skip if same) _____ City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

By signing this sheet I agree with the following statements:

- * I have provided accurate demographic and insurance/billing information.
- * I understand that it is my responsibility to contact Quality Orthopaedic Care, P.C. if I move, change insurance policies or have other changes to the information listed above.
- * I authorize Quality Orthopaedic Care, P.C. to: bill my insurance company for services provided and if necessary release health information, to the insurance company to process my insurance claims.
- * I request payment go to Quality Orthopaedic Care, P.C. for the services provided.
- * I have received the following documents and understand it is my responsibility to review them.
 Quality Orthopaedic Care, P.C. Notice of Privacy Practices Policy – included in this packet
 Quality Orthopaedic Care, P.C. Financial Policy – included in this packet

Parent/Guardian Signature: _____ Date: _____