Patient Information

Patient's Name ______________________ Phone ______________________
(Home) (Cell)

Address ______________________ City ______________________ State ________ Zip __________

County of Residence ______________________ Date of Birth ____ /____ /____ Sex M F

Mother's Name ____________ ____________ ____________ Date of Birth ___/___/___ SS# ____________
(First) (Maiden) (Last)

Address (if different) ______________________ Email: ______________________

Employer ______________________ Phone ______________________
(Home) (Cell) (Work)

Father's Name ______________________ Date of Birth ___/___/___ SS# ____________

Address (if different) ______________________ Email: ______________________

Employer ______________________ Phone ______________________
(Home) (Cell) (Work)

Legal Guardian/Step-Parents ______________________

Emergency Contact (other than parents) ______________________ Relationship ______________________

Phone No. ______________________ Preferred language to speak ______________________

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Insurance ______________________ Subscriber's Name ______________________

Group # ______________________ ID # ______________________ Date of Birth ______________________

Secondary Insurance ______________________ Subscriber's Name ______________________

Group # ______________________ ID # ______________________ Date of Birth ______________________

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Names of other family members who are patients of ours ______________________

______________________ How did you learn about us? ______________________

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

I authorize the release of protected health information to any consultant for the purpose of continuing care. I authorize the release of information acquired in the course of my child's examination for the purpose of filing insurance claims. I assign insurance payment directly to Burlington Pediatrics. I understand that I am ultimately responsible for payment of charges, whether or not they are covered by insurance. This authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be as valid as the original.

Date ______________________ Signature ______________________

Relationship to Patient ______________________

PATIENT INFORMATION CHANGES

1. ________ No changes. Entered in computer by: ______________ (intials)

________ Address Change ____

________ Phone # Change _____________________ Cell # Change ____________________

________ Insurance Co. Change ____________________________ Group # _____________________

ID # _______________________ Subscriber's Name _________________________

Subscriber's DOB ____________

________ Emergency Contact Change _____________________ Relationship to Patient _____________

Phone# __________________

→ Date ____________ Signature ________________________ Relationship to Patient _______________

2. ________ No changes. Entered in computer by: ______________ (intials)

________ Address Change ____

________ Phone # Change _____________________ Cell # Change ____________________

________ Insurance Co. Change ____________________________ Group # _____________________

ID # _______________________ Subscriber's Name _________________________

Subscriber's DOB ____________

________ Emergency Contact Change _____________________ Relationship to Patient _____________

Phone# __________________

→ Date ____________ Signature ________________________ Relationship to Patient _______________

3. ________ No changes. Entered in computer by: ______________ (intials)

________ Address Change ____

________ Phone # Change _____________________ Cell # Change ____________________

________ Insurance Co. Change ____________________________ Group # _____________________

ID # _______________________ Subscriber's Name _________________________

Subscriber's DOB ____________

________ Emergency Contact Change _____________________ Relationship to Patient _____________

Phone# __________________

→ Date ____________ Signature ________________________ Relationship to Patient _______________