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Patient Information (Confidential) **Date**: ______________________

Name: ____ - ______________
Last First Middle Preferred to be called

DOB: _____/_____/_______ ☐ M ☐ F Best Email address: ______________________________

Primary Address: ______________________________ **City:** ______________ **St:** _____ **Zip:** _________

Primary Phone: (_____) ______________________ Alternate Phone: (_____) ______________________
Landline/Cell/Work Landline/Cell/Work

Child lives with: ☐ Both Parents ☐ Mom ☐ Dad ☐ other

Medical Guardian/authorization for medical Information: ☐ Both Parents ☐ Mom ☐ Dad ☐ other

Please define other: ____

Mother: ____ DOB: _____/_____/________

Address: ______________________________ **City:** ______________ **St:** _____ **Zip:** _________

☐ Same as primary address

Primary Phone: (_____) ______________________ Alternate Phone: (_____) ______________________
Landline/Cell/Work Landline/Cell/Work

Father: ____ DOB: _____/_____/________

Address: ______________________________ **City:** ______________ **St:** _____ **Zip:** _________

☐ Same as primary address

Primary Phone: (_____) ______________________ Alternate Phone: (_____) ______________________
Landline/Cell/Work Landline/Cell/Work

Guardian: ____ DOB: _____/_____/________
Relationship to patient

Address: ______________________________ **City:** ______________ **St:** _____ **Zip:** _________

☐ Same as primary address

Primary Phone: (_____) ______________________ Alternate Phone: (_____) ______________________
Landline/Cell/Work Landline/Cell/Work

Emergency Contact: ____ - ______________
Phone

Insurance Information:

Company/Plan name: ______________________ Insured ID# ______________________ Eff Date: __________

Insured Members name: ______________________________ Relationship to Pt: ______________________

Name of Employer: ______________________________ Group# ______________________

It is **YOUR** responsibility to know your insurance benefits. As a courtesy, Pediatrics of Okaloosa will attempt to verify your health insurance benefits, and or necessary authorizations for you. Please be aware, this is only "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. I give Pediatrics of Okaloosa permission to file claims with the above insurance company on my behalf.

Signature: ____ Date: ____________________