MOUNTAIN PEDIATRICS

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Patient Information:

Full Name_____

M ◯ F ◯ DOB_____/_____/_____ ***(list siblings on 2nd page, only one form is required for all children)***

Physical Address_____

City_____ State_____ Zip_____-_____ (all 9 digits)

Home Phone #_____ Detailed Messages OK? Yes ◯ No ◯

Mailing Address (If Different Than Above) _____

City, State, Zip_____

*Preferred Pharmacy Name, Location*_____

1st Guardian:

Name_____ Relationship to Patient_____

Email_____ ***Appointment Reminders Are Emailed.***

Address (if different than patient) _____

City, State, Zip_____

Cell #_____ Home #_____ Wk #_____

Preferred Method of Contact: _____ Detailed Messages OK? Yes ◯ No ◯

2nd Guardian or Emergency Contact:

Name_____ Relationship to Patient_____

Email_____ ***Appointment Reminders Are Emailed.***

Address (if different than patient) _____

City, State, Zip_____

Cell #_____ Home #_____ Wk #_____

Preferred Method of Contact: _____ Detailed Messages OK? Yes ◯ No ◯

Siblings:

Name_____ M ◯ F ◯ DOB_____/_____/_____

Name_____ M ◯ F ◯ DOB_____/_____/_____

Name_____ M ◯ F ◯ DOB_____/_____/_____

Insurance Information:

Insurance_____ ID #_____Group #_____

PLEASE GIVE YOUR INSURANCE CARD AND I.D. TO THE RECEPTIONIST FOR SCANNING

MAIN CARDHOLDER NAME: _____ Relationship to Patient_____

IMPORTANT: Date of Birth of Main Cardholder (Guarantor) _____/_____/_____

IMPORTANT: Social Security # OF Main Cardholder (Guarantor) _____-_____-_____

Employer_____ Wk #_____

Email_____ ***Communication is Often Emailed.***

Address _____

City, State, Zip_____

Cell #_____ Home #_____

Preferred Method of Contact: _____ Detailed Messages OK? Yes ◯ No ◯

- **Please recognize that health insurance is a contract between you and your insurance company. We will bill your insurance company for your convenience; however, we are not in control over the terms of your contract with them.**

I understand that online verification of active insurance does not guarantee coverage. (Initial) _____

I understand that I am responsible for all non-covered services that are provided. (Initial)_____

I hereby authorize my insurance company to pay directly to Mountain Pediatrics. I am aware of Mountain Pediatrics financial and office policies. By signing this form, I agree to all the terms and conditions in the financial and office policies for any patient of Mountain Pediatrics for which I am the parent/ legal guardian or responsible party. There is a copy of our policies on the website (www.mountainpeds.com) which I can reference at any time.

How did you hear about us? _____

*Print Name*_____ *Sign Name*_____

*Relationship to Patient*_____ *Date*_____

NOTE: WE ARE DOING OUR BEST TO BE GREEN! WE WILL BE EMAILING REMINDERS & INVOICES.