WELCOME TO ROCKY MOUNTAIN PEDIATRICS

Please Complete all Fields and Sign

Patient's Name:____
Last **First** **Middle**

Birthdate: ___________________ **Sex:**_____**Male**____**Female** **Social Security:**_____-____-______

Address:____
Street **City** **State** **Zip**

Home Phone:_______-_______-__________ **Cell Phone (Mother):**_________-________-___________

Cell Phone (Father):_______-______-__________ **Email**____

Contact preference: Phone______ **Text**______ **Email**______

Emergency Contact:______________________________ **Phone:**________-________-____________

Insurance Co:_________________________ **Ins ID:**_________________ **Policy Holder:**_______________
(Please provide a copy of the ins card/cards)

2nd Ins:________________________________ **Ins ID:**_________________ **Policy Holder:**_______________

Mother:________________________________ **Soc Sec:** _____-_____-________ **Birthdate:**_____/_____/___
(Please provide Photo I.D.)

Employer:__________________________**Emp Phone:** _____-_____-______ **Occupation:**_______________

Father:________________________________ **Soc Sec:** _____-_____-________ **Birthdate:**_____/_____/____
(Please provide Photo I.D.)

Employer:__________________________**Emp Phone:** _____-_____-______ **Occupation:**_______________

Address if different than patient:____
Street **City** **Zip**

Missed Appointment Policy:

________ (**initial**) Scheduled appointments that are not kept or cancelled within a timely manner are considered a **NO SHOW**. If there are more than **THREE** no shows, Rocky Mountain Pediatrics has the right to terminate the patient from the practice.

Permission to bring patient in for appointments:

For the safety of your child, please list the people you give permission to bring your child into the office for their appointments. We will ask for a photo I.D. at the time of the appointment to confirm they are on this list.

Name: ___________________________________ **Relationship:** _______________

Address: _________________________________ **Phone:** _____________________

Name: ___________________________________ **Relationship:** _______________

Address: _________________________________ **Phone:** _____________________

Name: ___________________________________ **Relationship:** _______________

Address: _________________________________ **Phone:** _____________________

(This list may be updated at any time. If you want to update it, please request a new form.)

I understand the following: (Please initial each line)

______ Rocky Mountain Pediatrics bills my insurance company as a courtesy.
______ I am liable for any services provided.
______ Copays are due at the time of service; an additional fee applies if billed.
______ Deductible or coinsurance portions are due within 90 days of the services provided.
______ Rebilling charges will be applied monthly for balances over 90 days.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

In order to process claims for benefits, I authorize Rocky Mountain Pediatrics, P.C. to release any medical information (medical history, symptoms, treatment, examination, results or diagnosis) regarding me/my child to the Administrator of my insurance plan or its representatives. I also authorize payment of medical benefits directly to Rocky Mountain Pediatrics, P.C. A photocopy of this authorization shall be considered as effective and valid as the original.

____ ____________________

PATIENT, PARENT/GUARDIAN SIGNATURE **DATE**