Primary Doctor_____ **Emerald Pediatrics** Date_____

LIST ALL CHILDREN WHO ARE PATIENTS AT Emerald Pediatrics - OLDEST CHILD FIRST

First _____ MI _____ Last _____ Male / Female DOB_____/_____/_____

First _____ MI _____ Last _____ Male / Female DOB_____/_____/_____

First _____ MI _____ Last _____ Male / Female DOB_____/_____/_____

First _____ MI _____ Last _____ Male / Female DOB_____/_____/_____

First _____ MI _____ Last _____ Male / Female DOB_____/_____/_____

First _____ MI _____ Last _____ Male / Female DOB_____/_____/_____

BEST CELL PHONE # TO RECEIVE APPOINTMENT REMINDER CALLS/TEXTS (_____) _____

PERSON WHO CARRIES THE PRIMARY INSURANCE_____ INS CO_____

PATIENT(S) PRIMARY ADDRESS:

Address_____City_____State_____Zip_____

Is this the primary billing address? ☐Yes ☐No

Parent(s) / Legal Guardian(s) that reside at the above address:

Name_____ Name_____

Relationship_____ DOB _____/_____/_____ Relationship_____ DOB _____/_____/_____

Cell# (____) _____ Wk#(____) _____ Cell #(____) _____ Wk#(____) _____

Email: _____ Email: _____

Employer_____ Occupation_____ Employer_____ Occupation_____

Has consent for medical care: ☐Yes ☐No Has consent for medical care: ☐Yes ☐No

OTHER PARENT(S) ADDRESS (IF APPLICABLE):

Address_____City_____State_____Zip_____

Is this the primary billing address? ☐Yes ☐No

Other Parent(s) / Legal Guardian(s) that reside at this address:

Name_____ Name_____

Relationship_____ DOB _____/_____/_____ Relationship_____ DOB _____/_____/_____

Cell#(____) _____ Wk#(____) _____ Cell#(____) _____ Wk# (____) _____

Email: _____ Email: _____

Employer_____ Occupation_____ Employer_____ Occupation_____

Has consent for medical care: ☐Yes ☐No Has consent for medical care: ☐Yes ☐No

Please note: You must complete a separate Consent For Medical Care form if you wish for anyone other than a parent or legal guardian to accompany your child(ren) to their appointments.

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All Other Insurance Companies and/or Third Party Payers: I HEREBY AUTHORIZE Emerald Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Emerald Pediatrics and or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Medicare and Medicaid: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration, Medicare, Medicaid, or it's intermediaries or carriers any and all information needed for this or a related Medicare or Medicaid claim. I authorize and request that payment be made directly to Emerald Pediatrics.

Guarantee of Payment: I UNDERSTAND that filing claim with my insurance company or other third party payor, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Emerald Pediatrics to me or the patient indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Worker's Compensation and/or claims due to personal injury accidents/illnesses.

I AGREE that this authorization shall be valid until rescinded or replaced on a later date.

PARENT/GUARDIAN _____ DATE_____