HEALTHY KIDS PEDIATRICS
PATIENT INFORMATION FORM

Staff Only:

File in _____Chart **Acct. #: _____** **Date: _____**
(Patient's Name)

HOME ADDRESS: _____ HOME PHONE #: _____

_____ CELL PHONE #: _____

School: _____ Phone #: _____ Parental status: Married Single Widowed Divorced

LEGAL GUARDIAN AND EMERGENCY CONTACT

MOTHER'S NAME: _____ FATHER'S NAME: _____

HOME ADDRESS: _____ HOME ADDRESS: _____

_____ _____

PHONE #: _____ PHONE #: _____

BUSINESS PHONE #: _____ BUSINESS PHONE#: _____

CELL PHONE #: _____ CELL PHONE #: _____

E-MAIL: _____ E-MAIL: _____

OTHER EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ CELL PHONE #: _____

I authorize my physician's office to contact me by using any of the above contact information _____
Please Initial

INSURANCE

PRIMARY INS: _____ POLICY #: _____ GROUP #:_____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

RELATIONSHIP: _____ EMPLOYER: _____

SOCIAL SECURITY #**:** _____ ADDRESS: _____

DATE OF BIRTH: _____ BUSINESS PHONE: _____

SECONDARY INS: _____ POLICY #: _____ GROUP #:_____

POLICY HOLDER: _____ EFFECTIVE DATE: _____

RELATIONSHIP: _____ EMPLOYER: _____

SOCIAL SECURITY #**:** _____ ADDRESS: _____

DATE OF BIRTH: _____ BUSINESS PHONE: _____

PHARMACY INFORMATION

LOCAL PHARMACY_____ **MAIL AWAY PLAN**: _____

ADDRESS: _____ ADDRESS: _____

PHONE #: _____ PHONE #: _____FAX: _____

CHILD'S NAME	DATE OF BIRTH	AGE	PRIMARY INS. ID #	SECONDARY INS. ID#
1				
2				
3				
4				
5				
6				

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PATIENT INFORMATION

By my signature below I affirm; All of the information included on this form is correct and accurate. I will be responsible to inform this office of any changes in address, phone number, employment, and insurance information by requesting and completing a new information form. I will assume full responsibility for informing my insurance carrier that Madeline Pugliese, DO is my primary care physician or I will get the necessary referral. Any outstanding balance such as co-pay/co-ins, deductibles, denials due to change in coverage or non-participating plans is patient responsibility.

FINANCIAL RESPONSIBILITY:

- I hereby assign my insurance benefits to be paid directly to Healthy Kids Pediatrics and/or Madeline Pugliese, DO.

- I understand I am financially responsible for all non-covered services as well as any patient balance. Outstanding patient responsibility older than 60 days after the date of service will be charged a late fee of 1.5% per month. Co-pays, which are not paid at the time of service and require a patient billing statement, will be charged an additional processing fee of $25.00.

- If a check is returned for insufficient funds, a $25.00 bank fee will be added to the account balance.

- If the account goes to a collection attorney due to non-payment, the responsible party will also be responsible to pay all attorney fees, filing fees, and other court/judgment costs.

I acknowledge that I received Healthy Kids Pediatrics' Notice of Privacy Practices.

In order to help alleviate the number of forms to be filled out per family, Healthy Kids Pediatrics will make a copy of this signed document and place one in each child's chart with the understanding that the copies will serve as an original. _____
(Please Initial)

Parent/Legal Guardian Signature_____ Date: _____