

ROCKY MOUNTAIN HEALTH CENTERS PEDIATRICS PC

CHART # _____

New Patient

Established Patient

Today's Date: _____

PATIENT INFORMATION

Patient Name (Please Print): _____ Date of Birth: ____/____/____ Sex: M F
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____ Home Phone: ____-____-____
How Did You Hear About Us? _____ Child's Physician: Reddy Mourani

PARENT INFORMATION

Responsible Party Mother Father Other

Name of Mother: _____ Home Phone: ____-____-____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____ Cell Phone: ____-____-____
Employer: _____ Work Phone: ____-____-____
Mother's Date of Birth: ____/____/____ Mother's Social Security Number ____-____-____

Name of Father: _____ Home Phone: ____-____-____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____ Cell Phone: ____-____-____
Employer: _____ Work Phone: ____-____-____
Father's Date of Birth: ____/____/____ Father's Social Security Number ____-____-____

EMERGENCY CONTACT (Not Living With You)

Name: _____ Phone #: ____-____-____ Relationship: _____

INSURANCE INFORMATION

If this form is not complete with a copy of your insurance card, we will not be able to bill your insurance and you will be responsible for your bill.

Under whose insurance is the child insured Mother Father Other

Primary Insurance: _____ Employer: _____
Policy Holder Name: _____ Policy Holder Date Of Birth: ____/____/____
Policy Holder ID: _____ Group # _____ Copay Amount: \$ _____

Secondary Insurance: _____ Employer: _____
Policy Holder Name: _____ Policy Holder Date Of Birth: ____/____/____
Policy Holder ID: _____ Group # _____ Copay Amount: \$ _____

OTHER FAMILY MEMBERS SEEN IN THIS OFFICE

<u>Name</u>	<u>Sex</u>	<u>Date of Birth</u>	<u>Relationship to Patient</u>
_____	M F	____/____/____	_____
_____	M F	____/____/____	_____
_____	M F	____/____/____	_____

Assignment Of Insurance Benefits: I hereby authorize payment of medical benefits directly to RMHC Pediatrics P.C. I further authorize the release of any medical information necessary for processing the insurance claim. I permit a copy of this authorization to be valid as the original. I understand that all costs not paid by the insurance will become my responsibility unless otherwise prohibited by state or federal regulations.

Permission to Treat a Minor (Under age 18 years): In the event of an emergency and I cannot be contacted, I give my permission to RMHC Pediatrics P.C. to treat my child in their office as required by the events of that emergency situation.

I acknowledge that I have received and read the **NOTICE OF PRIVACY POLICY AND PROCEDURES**

_____/_____/_____
Signature Relationship to Patient Date