Date: _____

DEMOGRAPHIC DATA

Please list full legal name of child/patient:

Name: First_____**Middle**_____**Last**_____**DOB**_____**Sex**_____

Patient's Home Address:_____City:_____State:_____ZIP:_____

Mother's Name:_____ Date of birth____/____/____SSN: _____

Home Phone:_____ Mobile Phone:_____

Address: (if different from above):_____

Employer:_____ Work #:_____

Father's name:_____ Date of birth____/____/____ SSN:_____

Home Phone:_____ Mobile Phone:_____

Address: (if different from above): _____

Employer:_____ Work #: _____

Email Address: _____

Can we send you secure text notifications regarding your child's medical and appointment information from Athena

health (Electronic Medical Records System)? Yes ☐ No ☐

Preferred Pharmacy/Address :

_____

HOW WERE YOU REFERRED TO THE PRACTICE?

☐ Friends and Family
☐ Insurance Company
☐ Internet
☐ MD:_____

☐ Current Patient
☐ Print Add

☐ Other:_____

WHO IS FINANCIALLY RESPONSIBLE:

Name:_____

Address if not same as Patient:_____

Relationship:_____

If father or mother is not responsible, please complete the following:

Employed? ☐Y ☐N

Name of employer: _____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

POLICY HOLDER AND INSURANCE INFORMATION

Do you have Insurance? ☐Y ☐N
Are you Policy Holder? ☐Y ☐N

Name of Company:_____
Subscriber Name: _____
Subscriber Number:_____
Group Number:_____
Eligibility Date:_____
Date of Birth:_____
Address if different from Patient:

_____

_____

Secondary Insurance? ☐Y ☐N
Are you Policy Holder? ☐Y ☐N

Name of Company:_____
Subscriber Name: _____
Subscriber Number:_____
Group Number:_____
Eligibility Date:_____
Date of Birth:_____
Address if different from Patient:

_____

_____

EMERGENCY CONTACT

Name:_____

Contact Phone Number:_____

Relationship:_____

Address if different from Patient: _____

Home Phone: _____

Cell Phone:_____

Work Phone:_____

I understand that if any of the above information changes that it is my responsibility to provide Wildflower Pediatrics with a written update of information indicating all necessary changes.

I understand that my primary insurance company will be billed for me but that all co-pays, co-insurance, non-covered items and deductible amounts are due at the time of service. I also understand that if my insurance company denies a charge for any reason, I will be billed and ultimately responsible for that charge. In addition, if a claim is disputed by the insurance company for any reason, and payment has not been made in a timely manner, I will be responsible for the payment of the charges until the dispute has been resolved and the insurance company makes payment on the charges in question. Lastly, I authorize insurance benefits to be paid directly to the physician and the release of any medical records that may be required by the insurance company in order to pay out those benefits. This assignment of benefits is irrevocable, and a photo static copy shall be considered as legal and binding as the original. In event of default for any reason, parent/guardian is responsible for any and all attorney fees, collection fees and all courts costs.

Patient Signature (if minor parent/guardian sign below):_____

Date:_____

Responsible Party:

Signature:_____

Date:_____

Relationship:_____