Kids First Pediatric Group, LLC

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PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____
Preferred (Nickname):_____ Suffix: _____
Date of Birth: _____ Sex: _____ SS#: _____ Race: _____
Ethnicity: _____
Address: Line1: _____ Line2: _____
Zip: _____ City: _____ State: _____ County: _____
Phone: Home: _____ Daytime/Cell: _____
Referred by: _____

Preferred Pharmacy Name: _____ Location: _____
Pharmacy Number: _____

GUARANTOR INFORMATION

Mother:
Last Name: _____ First: _____ Middle: _____
Prefix: _____ Suffix: _____ Date of Birth: _____ SS#: _____
Martial Status: _____ Primary Language: _____
Address: Line1: _____ Line2: _____
Zip: _____ City: _____ State: _____ County:_____

Phone: Home: _____ Work: _____ Cell: _____
Email: _____

Employer: Name: _____
Address: _____

Father:
Last Name: _____ First: _____ Middle: _____
Prefix: _____ Suffix: _____ Date of Birth: _____ SS#: _____
Martial Status: _____ Primary Language: _____
Address: Line1: _____ Line2: _____
Zip: _____ City: _____ State: _____ County:_____

Phone: Home: _____ Work: _____ Cell: _____
Email: _____

Employer: Name: _____
Address: _____

* Emergency Contact: _____ _____ _____
Name Daytime Contact # Relationship to Patient

Patient's Name: _____

INSURANCE INFORMATION

Responsible Party (Mother/Father/Gaurdian): _____

Primary Insurance	Secondary Insurance
Carrier/Insurance Co.: _____	Carrier/Insurance Co.: _____
Group # : _____	Group #: _____
Member ID#: _____	Member ID#: _____
Insured Name: _____	Insured Name: _____
Relationship to patient _____	Relationship to patient: _____

I hereby assign payment to Kids First Pediatric Group, LLC for all medical benefits otherwise payable to me under terms of my insurance contract as payment towards the total charges for professional services rendered. I understand that I am responsible for charges not covered under this assignment. Payment in full is expected when services are rendered. The undersigned agrees that they are jointly and severally liable for the payment of any services, medications, or other items provided to the patient. The filing of insurance by this office is a courtesy and shall not act to amend or void your obligation to pay the balance due. All obligations are due and payable upon receipt of statement. If any amount due shall require collections by or with the assistance of any attorney, the undersigned shall be additionally responsible for all attorney's fees, court cost, or other expenses of collection, not less than 15 % of the balance at the time of placement for collections. I hereby authorize Kids First Pediatric Group, LLC and /or it's staff to release medical information to insurance companies concerning the patient's illness and treatments.

All fees for laboratory studies that cannot be performed onsite and required being sent to an putside reference lab are the sole responsiblility of the parent and/or guarantor.

_____ _____

Patient or Guarantor's Signature Date

_____

Print Name