



### INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance?       Yes       No (Self-Pay)

Responsible Party:	Birth date:	Address:	Home phone:
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Occupation:	Employer:	Employer address:	Employer phone:
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Name of Primary Insurance Company:

Subscriber's name:	Birth date:	Group #:	Policy #:
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Patient's relationship to subscriber:       Self       Child       Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:
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Patient's relationship to subscriber:       Self       Child       Other

### FAMILY/CONTACT INFORMATION

Patient resides primarily with:

Both Parents       Parent #1 (list information below)       Parent #2 (list information below)

Legal Guardian: \_\_\_\_\_       Other: \_\_\_\_\_

Parents are:  Married       Divorced       Separated       Other: \_\_\_\_\_

Parent/Legal Guardian #1's Name and Birth Date:	Relationship to patient: What does your child call you? (e.g. Mom, Papa, etc)
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Home phone number:	Mobile number:	E-mail:
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Occupation:	Employer & Work Number:
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Lives with patient?    Yes    No      *If you do not live with the patient, please provide the address.*

The best way to reach me is:       Home number       Mobile number       Work number       E-mail

Puddle Dock Pediatrics may leave messages or lab results via:    Home #    Mobile #    Work #    E-mail

Parent/Legal Guardian #2's Name and Birth Date:	Relationship to patient: What does your child call you? (e.g. Mom, Papa, etc)
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Home phone number:	Mobile number:	E-mail:
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Occupation:	Employer & Work Number:
Lives with patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If you do not live with the patient, please provide the address (please disregard if same as Parent/Legal Guardian #1).</i>
The best way to reach me is: <input type="checkbox"/> Home number <input type="checkbox"/> Mobile number <input type="checkbox"/> Work number <input type="checkbox"/> E-mail	
Puddle Dock Pediatrics may leave messages or lab results via: <input type="checkbox"/> Home # <input type="checkbox"/> Mobile # <input type="checkbox"/> Work # <input type="checkbox"/> E-mail	

ADDITIONAL CONTACT QUESTIONS
Who should receive billing statements?
May all contacts have access to the patient's records? <input type="checkbox"/> Yes <input type="checkbox"/> No
If parents are divorced, separated, or unmarried, please fill out this section:
Who has custody?
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Puddle Dock Pediatrics, PLLC or insurance company to release any information required to process my claims.</p> <p>I give permission for Puddle Dock Pediatrics to contact me via e-mail and/or text message.</p> <p>_____</p> <p>Patient/Guardian signature <span style="float: right;">_____</span> Date</p>
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