

# Great Destinations Pediatrics P.C.

## PATIENT'S INFORMATION

Patient's Name _____	Sex M _____ F _____	Date of Birth _____
Patient's Name _____	Sex M _____ F _____	Date of Birth _____
Patient's Name _____	Sex M _____ F _____	Date of Birth _____
Patient's Name _____	Sex M _____ F _____	Date of Birth _____
Patient's Name _____	Sex M _____ F _____	Date of Birth _____
Patient's Name _____	Sex M _____ F _____	Date of Birth _____
Patient's HomeAddress _____		Home Phone(____)-____-____
Street	City	ST      Zip

**Marital status of child's parents (Please Check One):**

Married \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

## PARENT'S INFORMATION

Please Circle ( Natural, Step, Guardian)	
Mother's Name _____	(Maiden Name) _____ SS# _____-____-____
HomeAddress _____ Home Phone(____)-____-____	
Street	City      ST      Zip
Employer _____	Cell or Work (____)-____-____      Email _____
Occupation _____	Date of Birth _____
Please Circle (Natural, Step, Guardian)	
Father's Name _____	SS # _____-____-____
Home Address _____ Home Phone(____)-____-____	
Street	City      ST      Zip
Employer _____	Cell or Work (____)-____-____      Email _____
Occupation _____	Date of Birth _____

## INSURANCE INFORMATION

Primary Insurance Company Name	Name of Policy Holder	Policy/ID Number	Group Number
Secondary Insurance Company Name	Name of Policy Holder	Policy/ID Number	Group Number

**Name of Nearest Relative:** Name \_\_\_\_\_ Phone \_\_\_\_\_  
**(Not living with you)**  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

### AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly from my insurance company to the physician's of Great Destinations Pediatrics for Medical treatment(s) provided to my Child. I understand that payment in full of my responsible portion is required at the time of visit. If Great Destinations Pediatrics (GDP) is not a provider on my insurance, full payment is due on the date of service. If GDP is a provider on my insurance, then any deductibles, co-pays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay reasonable charges, attorney's fees, and all other costs. I hereby authorize GDP to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and health care operations of my child.

### FINANCIAL/OFFICE POLICY & HIPAA:

I have read and understand the foregoing financial and office policy and agree to abide by the terms of this policy. I also acknowledge that I have received a copy of the Notice of Privacy Practices, including Omnibus Rule.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Responsible Party Signature