

# Surprise Pediatrics – Patient Information

**\*\* EVERY line must be completed \*\***

Patient Name: \_\_\_\_\_ Sex: M F Birthday: \_\_\_\_\_  
First Name Middle Initial Last Name

**MOTHER** Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email: \_\_\_\_\_ Responsible for the bill? Yes No

**FATHER** Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email: \_\_\_\_\_ Responsible for the bill? Yes No

Primary Insurance: \_\_\_\_\_ Address: \_\_\_\_\_  
Identification # \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Relationship to child: mother father other: \_\_\_\_\_

**\*\*\*\*\* IF YOU HAVE SECONDARY INSURANCE, please complete Secondary Insurance form \*\*\*\*\***

The following people have my permission to authorize medical treatment if we, the parents/legal guardians, are not available to give consent. I understand that it is our responsibility to notify Surprise Pediatrics in writing of any changes to this list.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
DOB: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
DOB: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Initials: \_\_\_\_\_ I have reviewed the posted Notice of Privacy Practices for Surprise Pediatrics as part of the Health Insurance Portability and Accountability Act (HIPAA).

Initials: \_\_\_\_\_ I have received a copy of the Surprise Pediatrics Financial and Office Policies (July 2010). I agree to abide by all of its terms and conditions knowing that failure to comply may result in discharge from the practice.

Initials: \_\_\_\_\_ I am responsible for knowing my insurance benefits and updating all information with my insurance(s) as needed.

I hereby confirm that the above information is complete and accurate, and that I am the responsible party for this minor. I hereby authorize Surprise Pediatrics to examine and treat my child when necessary. I also authorize the release of protected health information, acquired in the course of examination, to carry out treatment, payment, and the healthcare operations of my child. I authorize my insurance benefits to be paid directly to Surprise Pediatrics. I understand that I am responsible for any unpaid balance for services rendered but not covered by my insurance policy(ies). If my account is referred for collection, I agree to pay the balance due, collection fee of 33%, all attorney's fees, and any other associated costs incurred.

Guarantor/Parent Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor/Parent Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_