RAMBLC Pediatric Medical Group, Inc.

Doctor: ☐ New Patient ☐ Update

Patient Information

	Name (Last, First)	*Sex*	*Birth date*	*SS#*
1.	______________________________	M or F	____/____/______	_____-____-_____
2.	______________________________	M or F	____/____/______	_____-____-_____
3.	______________________________	M or F	____/____/______	_____-____-_____
4.	______________________________	M or F	____/____/______	_____-____-_____

Parent or Guardian Information

Responsible Party	*Other Parent or Guardian*
________________________________	________________________________
Birth date ____/____/______	Birth date ____/____/______
SS# _____-____-_____	SS# _____-____-_____
Address __________________________	Address __________________________
City___________ State_____ Zip______	City___________ State_____ Zip______
Occupation________________________	Occupation ________________________
Home Phone (____) _____-________	Home Phone (____) _____-________
Work Phone (____) _____-________	Work Phone (____) _____-________
Cell / Pager (____) _____-________	Cell / Pager (____) _____-________
Relationship to Patient ______________	Relationship to Patient ______________
Patient(s) Lives With ______________	Referred by ______________________

Insurance and Emergency Contact Information

Insured ____________________

Primary Insurance Name________________ Group# ____________ ID#________________

Claims Payment Address: __________________________________ City ________________

State______ Zip____________ Effective Date: ____/____/_____

In an Emergency, please contact (other than above) _____________________

Relationship_________________ Phone (____) _____-________

Authorization for Treatment, Payment Agreement, and receipt of HIPPA Notice of Privacy Rights and Practices:

As parent or legal guardian, I give permission for the physicians at RAMBLC Pediatric Medical Group to treat the patient(s) listed above. I agree to pay for all services rendered in accordance with the financial policy of this office, and I authorize that my insurance benefits be paid directly to my physician at RAMBLC Pediatric Medical Group, Inc. I will promptly pay any charges not covered by my insurance company. I have received the HIPPA Notice of Privacy Rights and Practices.

Parent / Guardian Signature (X)_____________________________________Date:___/___/_______