Brighton Pediatrics, P.C.

PATIENT/GUARANTOR INFORMATION

Please fill in **all** information **completely** so that we may update our records and bill your insurance carrier

Patient Information:

Name: (Last) _____ **(First)** _____ **(MI)** _____
Birth date: _____ **Age** _____**Sex** _____ **Known Allergies:** _____
Address: _____ **(City)** _____ **(State)** _____**(Zip)** _____
Home Phone: _____ **Cell Phone:** _____

Responsible Party: (Last) _____ **(First)** _____ **(MI)** ___ **DOB**_____ **Relationship**_____
****Responsible Party SSN (Last 4 numbers only): xxx-xx-**_____
Home Phone: _____ **Cell Phone:** _____
Occupation: _____ Employer: _____ Work Phone #: _____

E-mail address: _____ **Sign up for patient portal** ☐ **yes** ☐ **no**

Other Parent/ Legal Guardian: (Last) _____ **(First)** _____ **(MI)** ____ **DOB** _____ **Relationship**_____
Home Phone: _____ **Cell Phone:** _____
Occupation: _____Employer: _____Work Phone #: _____

Emergency Contact (not the parent/guardian) Name: _____ **Relationship**_____ **Ph.#**_____

Due to the improved diagnoses and treatment of genetic and other diseases, the following information would be helpful to your child's medical care.

Patient's Race:
□ American Indian or Alaskan Native
□ Asian
□ Black or African American
□ Hispanic or Latino
□ Pacific Islander
□ White or Caucasian
□ Other _____
□ Declined

Patient's Ethnicity:
□ Not Hispanic or Latino
□ Hispanic or Latino
□ Declined

Preferred Language: (Please check one)
□ English
□ Spanish
□ Other _____

NEW PATIETNS ONLY – How did you hear about us?

- ○ Family/Friend
- ○ Platte Valley Hospital
- ○ Facebook
- ○ Google
- ○ Brighton Buzz
- ○ DEX Phone Directory
- ○ Insurance
- ○ Other: _____

INSURANCE INFORMATION:
Insurance Company: _____ Subscriber #/Member ID: _____ Group #: _____
Group Name _____ Phone Number: _____
Insured's Name: (Last) _____ (First) _____ (MI) ___ DOB_____

SECONDARY INSURANCE INFORMATION:
Insurance Company: _____ Subscriber #/Member ID: _____ Group #: _____
Group Name _____ Phone Number: _____
Insured's Name: (Last) _____ (First) _____ (MI) ___ DOB_____

Please provide a copy of your current insurance card(s).

Consent for Treatment

I hereby consent to the treatment of my child for routine medical care. I further understand I have the right to discuss proposed procedures or treatments with my physician, and to consent to, or refuse such procedures or treatments.

Consent and Assignment of Benefits/Pre-authorization and Financial Responsibility

I also hereby authorize payment of benefits by any third party directly to Brighton Pediatrics, P.C. for services rendered. I understand that it is my sole responsibility to obtain all pre-authorizations and to comply with all requirements of any insurance plan under which I am relying for coverage and to provide correct insurance information. I understand copayments, deductibles and any portion not covered by insurance are due on the date of service. I assume full financial responsibility for all charges (in accordance with insurance contracts when applicable) and agree to pay Brighton Pediatrics, P.C. in accordance with this agreement.

Parent/Legal guardian signature: _____**Relationship to child** _____ **Date** _____

We accept Cash, Check, and Visa or MasterCard