

Southeast Denver Pediatrics, P.C.  
2121 S. Oneida, Ste. 200 • Denver, Colorado 80224-2551 303 • 757-6418 • FAX 303 • 757-2209  
11960 Lioness Way, Suite 200 • Parker, Colorado 80134 303 • 471-5060 • FAX 303 • 471-5062

**PLEASE INCLUDE ALL INFORMATION**

**Children:**

Last Name	First Name	MI	Birthdate	Sex
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Primary Care Physician:  Hand  Sagel  Rodriguez  Schwartz  Miga  Carlson  Erdley

**Name of Friend/Relative/Emergency Contact:** \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

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Father  Mother  Other/Relationship \_\_\_\_\_

Father  Mother  Other/Relationship \_\_\_\_\_

Insurance Subscriber  Person Responsible for Bill

Insurance Subscriber  Person Responsible for Bill

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone : \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Phone : \_\_\_\_\_ Birthdate: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**DAYTIME/CELL PHONE:** \_\_\_\_\_

**DAYTIME/CELL PHONE:** \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext.: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Ext.: \_\_\_\_\_

.....

**INSURANCE INFORMATION**

Primary Insurance Co. Name: \_\_\_\_\_ Copay: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ ID/SSN#: \_\_\_\_\_

Group (GRP): \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Secondary Insurance Co. Name: \_\_\_\_\_ Copay: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ S.S./Subscriber #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to Southeast Denver Pediatrics for services rendered. **I understand that I am financially responsible for any balance not covered by insurance.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_