Please print and fill out completely

Lynchburg Pediatrics

INFO SHEET

434-385-7776 info@rdpeds.com
FAX 434-385-5846

PATIENT(S) Please list all children that are current patients at Lynchburg Pediatrics

LAST name (include suffix)	FIRST name	MI	Sex	Birthdate	SS#

Patient's Address:

Address:_____

City_____

State_____ Zip Code_____

Phone_____

□ Please check if you are 16 or older and prefer our office to contact you with labs and personal information

RESPONSIBLE PARTY

(TO WHOM BILLING STATEMENTS ARE SENT)

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Mother:_____ DOB:_____ Social Security: _____

Address: _____City_____ST_____Zip_____

Email:_____ Employer:_____ Work Phone:_____

Home Phone: _____ Cell Phone: _____

Father:_____ DOB:_____ Social Security:_____

Address:_____City_____ST_____ZIP_____

Email:_____ Employer:_____ Work phone:_____

Home phone: _____ Cell Phone: _____

Contact Preference: (Please circle ONE)

Mail Home Phone Work Phone Cell Phone Text Message

May we leave messages on your voice mail or with persons that may answer your phone? **Yes or NO**

Please provide the best number to reach you _____

***EMERGENCY CONTACT**: must include on HIPAA form Relationship to patient_____

Name: _____ Phone number: _____

Preferred Pharmacy: _____ Location:_____

PATIENT NAME:_____Patient Date of Birth_____

Preferred language at home (please circle)

English Spanish Arabic Chinese French German Italian Sign Language Russian Japanese, Other:_____

Race (please circle)

Black Black(non-Hispanic) Caucasian Hispanic White Hawaii or Pacific Am Indian Alaskan Asian Asian/Pacific Islander Patient declines/refuses

Ethnicity (please circle)

Hispanic/Latino Nonhispanic/Not Latino Filipino Patient declines/refuses

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INSURANCE INFORMATION **Please give insurance card to Receptionist**

- □ INSURED
- □ SELF-PAY

Billing Information-All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the Patient/Guardian is responsible for all fees; regardless of insurance coverage and is also required to pay co-pays at the time of service. Self-pay patients are expected to pay in **full** at the time of services unless other payment arrangements have been made with our Billing Office.

Primary Insurance Information:

Insurance Co Name:_____
Claims address: _____
ID Number:_____
Group Number:_____

Policy Holder:

Last Name: _____
First Name: _____
Relationship to patient:_____
Social Security No:_____
Date of Birth:_____
Employer:_____

Secondary Insurance Information:

Insurance Co Name:_____
Claims address: _____
ID Number:_____
Group Number:_____

Policy Holder:

Last Name: _____
First Name: _____
Relationship to patient:_____
Social Security No:_____
Date of Birth: _____
Employer: _____

Assignment and Release: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services. I also authorize the physician to release any information required to process this claim.
Right of Dismissal: I hereby acknowledge that the doctors reserve the right to and in fact do only see and treat patients covered by certain third-party insurers.

Signature:_____ Date:_____ Relationship to patient:_____