WELCOME TO PEDIATRIC PARTNERS OF NORTHERN KENTUCKY!

Please fill out this form as completely as possible so that we may bill your insurance for you. If you have any questions or need any help, please do not hesitate to ask. We are here to help you. When you are finished please let us make a copy of your insurance cards.

PLEASE FILL IN ***ALL*** BLANKS

TODAY'S DATE_____

PATIENT'S NAME: LAST_____ FIRST_____MI____ DOB_____
ADDRESS_____CITY_____STATE_____ZIP_____
RACE_____ETHNICITY_____SEX_____

PARENT'S NAME_____DOB_____RELATIONSHIP_____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE # (_____) _____WORK # (_____) _____
EMAIL_____ SOC SEC#_____
PARENT'S NAME_____DOB_____RELATIONSHIP_____
ADDRESS_____CITY_____STATE_____ZIP_____
PHONE #(_____) _____WORK# (_____) _____
EMAIL _____**SOC SEC #**_____

PRIMARY INSURANCE INFORMATION
SUBSCRIBER'S NAME LAST_____FIRST_____MI_____
DOB_____ SEX: _____ SOCIAL SECURITY**#**_____RELATIONSHIP_____
ADDRESS_____CITY_____STATE _____ ZIP_____
EMPLOYER_____ADDRESS_____
INSURANCE NAME_____ EFFECTIVE DATE_____
ID#_____ GROUP#_____COPAY AMOUNT$_____
CLAIMS ADDRESS_____
REFERRAL REQUIRED TO SEE SPECIALISTS? Y OR N
PATIENT'S RELATION TO SUBSCRIBER PLEASE CIRCLE ONE CHILD STEPCHILD GRANDCHILD OTHER_____

DO YOU HAVE SECONDARY INSURANCE? Y OR N

EMERGENCY CONTACT NAME *OTHER* THAN PARENTS:
LAST_____FIRST_____
ADDRESS_____APT_____
CITY_____STATE_____ZIP_____
PHONE #_____RELATION TO PATIENT_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it's my responsibility to inform this office of any changes. I authorize your staff to perform the necessary services my child may need. I hereby authorize my insurance benefits to be paid directly to Pediatric Partners of Northern Kentucky realizing that I am responsible to pay non-covered services and procedures and I hereby authorize the release of pertinent medical information to the insurance carrier(s). I understand I am responsible for any fees that may be incurred in collecting those fees.

SIGNATURE_____DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
I affirm that I have received a copy of the Notice of Privacy Practices for Pediatric Partners of Northern Kentucky.

SIGNATURE_____DATE_____

Please turn over and fill out back

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S NAME LAST_____FIRST_____MI_____
DOB_____ SEX_____ **SOCIAL SECURITY#**_____
ADDRESS_____CITY_____STATE _____ ZIP_____
EMPLOYER_____ADDRESS_____
INSURANCE NAME_____ **EFFECTIVE DATE**_____
ID#_____ GROUP#_____COPAY AMOUNT$_____
CLAIMS ADDRESS_____
REFERRAL REQUIRED TO SEE SPECIALISTS? Y OR N
PATIENT'S RELATION TO SUBSCRIBER PLEASE CIRCLE ONE CHILD STEPCHILD GRANDCHILD OTHER_____

When parent(s) or legal guardian(s) cannot be with a child(ren) for medical services and/or subsequent vaccine administration in a series, the form below must be completed identifying those individuals you anticipate may be bringing your child(ren) in for services in your absence other than parent or legal guardian(s).
Patients 18 and older may sign their own consent forms

I am the Parent/Legal Guardian of the following child/children:
Name: _____ DOB: _____ /_____ /_____

Name: _____ DOB: _____ /_____ /_____

Name: _____ DOB: _____ /_____ /_____

Name: _____ DOB: _____ /_____ /_____

I give permission to …
_____ Relationship to Patient: _____ Phone: _____

_____ Relationship to Patient: _____ Phone: _____

_____ Relationship to Patient: _____ Phone: _____

… to give legal consent for any and all medical treatment, subsequent vaccine administration including permission to be contacted in my absence.

_____ _____ _____
Parent / Legal Guardian / Patient (18+) Signature Date Phone

This authorization will remain in effect until we are otherwise notified or the child(ren) reaches the age of 18 years.