Landen Lake Pediatrics

Names of Children (Please Print)

Last Name	First Name	Middle	Sex M/F	Date of Birth MM/DD/YYYY	Primary Language	Race	Ethnicity Hispanic or Latino Not Hispanic or Latino Decline

(Please list additional children on the back)

Patient Address_____City_____

ST_____Zip_____

Home Phone Number ( )_____

Emergency Contact Other Than Parents_____

Relationship of Emergency Contact_____

Phone Number of Emergency Contact ( )_____

Preferred Pharmacy _____

Phone ( )_____

How did you hear about our office?_____

Preferred Provider_____

Responsible Party Information

Father/Legal Guardian Responsible Party? Y or N

Mother/Legal Guardian Responsible Party? Y or N

Name	Name
Birthdate SSN	Birthdate SSN
Address	Address
City ST Zip	City ST Zip
Home Phone ( )	Home Phone ( )
Cell Phone ( )	Cell Phone ( )
Employed By	Employed By
Occupation	Occupation
Work Phone ( )	Work Phone ( )
Email Address	Email Address

Insurance Information

(Please furnish us with a copy of your insurance card.)

NOTE: Patients who carry health insurance should remember that payment for our services is the responsibility of the insured, and patients are expected to pay their co-pay at the time of service. Any balance not covered by insurance is due and payable upon receipt of billing statement.

Primary Insurance	Secondary Insurance
Name of Insured	Name of Insured
DOB:	DOB:
Relationship to Patient	Relationship to Patient
ID # Group#	ID # Group#

ACKNOWLEDGEMENT OF RECEIPT: I hereby acknowledge that I have received the Notice of Privacy Practices of Landen Lake Pediatrics. I understand this notice contains information regarding how Landen Lake Pediatrics uses my medical information.

ASSIGNMENT AND RELEASE: I hereby authorize Landen Lake Pediatrics to treat and to furnish information to insurance carriers concerning treatment, and I hereby assign to the provider all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. I also authorize Landen Lake Pediatrics to make reasonable disclosures of my children's Personal Health Information to parents, schools, doctors, and others involved in their care, unless otherwise specified. I give permission for Landen Lake Pediatrics to call and/or leave messages with practice related issues unless otherwise specified.

Parent's Signature:_____

Date_____