Bright Future Pediatrics

PATIENT INFORMATION SHEET
"To be completed by parent or guardian"
One form may be completed for all children IF the information listed below is same for all children.

PATIENT'S FULL NAME	DATE OF BIRTH	RACE/ETH	SEX	Preferred Doctor

BILLING ADDRESS:_____CITY_____STATE_____ZIP_____
PRIMARY CELL #:_____ ALT. PHONE # _____

- Numbers provided will be used for appointment reminders

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME_____
DOB_____
SOCIAL SECURITY #_____
ADDRESS_____
PREFERRED PHONE # _____
EMPLOYER_____
WORK PHONE_____
EMAIL ADDRESS_____

MOTHER'S NAME_____
DOB_____
SOCIAL SECURITY #_____
ADDRESS_____
PREFERRED PHONE # _____
EMPLOYER_____
WORK PHONE_____
EMAIL ADDRESS_____

PRIMARY INSURANCE

COMPANY_____
EFFECTIVE DATE_____
SUBSCRIBER NAME_____
SUBSCRIBER DATE OF BIRTH_____
EMPLOYER_____
GROUP #_____
SUBSCRIBER #_____

SECONDARY INSURANCE

COMPANY_____
EFFECTIVE DATE_____
SUBSCRIBER NAME_____
SUBSCRIBER DATE OF BIRTH_____
EMPLOYER_____
GROUP #_____
SUBSCRIBER #_____

PLEASE PRESENT CHILD'S INSURANCE CARD SO IT CAN BE COPIED

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME_____ RELATIONSHIP_____
ADDRESS_____CITY_____STATE_____ ZIP_____
PREFERRED PHONE #_____ ALTERNATE PHONE #_____

RELEASE OF INFORMATION

I consent to the use and release of any information, including the diagnosis and the records of any treatment or examination rendered by the medical practice of Bright Future Pediatrics to the above individuals listed who have authority to act on behalf of the patient child (children), insurance companies, governmental payers, healthcare practitioners and other persons/entities for purposes of treatment, payment and business operation of the medical practice of Bright Future Pediatrics.

I, the undersigned, authorize and request my insurance company or governmental payer to pay directly to any doctor of this medical practice insurance benefits otherwise payable to the undersigned.

FINANCIAL RESPONSIBILITY:

I, the undersigned, understand my insurance carrier may pay less than the actual bill for services. Regardless of insurance benefits, or the designation of some other responsible party above, I agree to be responsible for payment of all services rendered on my behalf or on behalf of my child (children) and/or dependents. If and when my child (children) and/or dependents are over the age of eighteen (18) years, I understand my financial responsibility for him/her/them will remain unless I have provided written notification to Bright Future Pediatrics that I will no longer be responsible prior to the rendering of services for said child (children) and/or dependent.

My signature below acknowledges I have read and received a copy of the office HIPAA Policy and Financial Policy.

_____ _____
Signature of Parent/Legal Guardian/Responsible Party **Date**

FOR OFFICE USE: UPDATED BY:_____ DATE:_____ UPDATED: 12/21/2023