

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 _____
HOME PHONE (_____) _____ NICKNAME _____ SEX: M F

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____
(TO WHOM SHOULD WE SEND THE STATEMENT?) _____ MUST BE PERSON WHO SIGNED FINANCIAL POLICY

MOTHER'S NAME _____ DOB _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE # (_____) _____ WORK # (_____) _____
CELL# (_____) _____ SOC SEC# _____

FATHER'S NAME _____ DOB _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE # (_____) _____ WORK# (_____) _____
CELL# (_____) _____ SOC SEC # _____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S NAME LAST _____ FIRST _____ MI _____
DOB _____ SEX: M F **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 _____

DO YOU HAVE SECONDARY INSURANCE? Y OR N IF YES, PLEASE SEE BACK OF FORM

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** _____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S NAME LAST _____ FIRST _____ MI _____

DOB _____ SEX: M F 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 _____