

QUESTIONNAIRE

Patient Information

Today's Date Month _____ Day _____ Year _____
Patient Name _____ Date of Birth _____ Sex _____
Address _____ City _____ Zip _____

Parent Information

Father's Name _____	Mother's Name _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
_____	_____
Phone: home _____ cell _____	Phone: home _____ cell _____
Employer _____	Employer _____
Address _____	Address _____
Phone _____	Phone _____
Social Security # _____	Social Security # _____
Occupation _____	Occupation _____

INSURANCE INFORMATION

Name of Insurance Company _____
Name of Policy Holder _____ Relationship to child _____
Policy ID# _____ Group# _____ Co-pay _____
Claims mailing address _____ Phone _____

AUTHORIZATION TO TREAT

Please list the people whose permission you grant to authorize treatment and seek information pertaining to the care of your child.

Name _____	phone _____	Relationship to child _____
Name _____	phone _____	Relationship to child _____
Name _____	phone _____	Relationship to child _____

HIPAA

I hereby acknowledge that I have received and have had the opportunity to review a copy of Grand Parkway Pediatrics NOTICE OF PRIVACY PRACTICES.

Signed _____ Relationship to child _____
Print Name _____ Date _____
Email Address _____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

By signing below, I agree to the following:

1. That I have the authority to authorize Grand Parkway Pediatrics to treat this patient.
2. That Grand Parkway Pediatrics has the authority to obtain medical information/records needed to treat this patient.
3. That Grand Parkway Pediatrics may release any and all medical records to secure payment for services rendered.
4. That the responsible party will make immediate payment for services rendered; if Grand Parkway Pediatrics is contracted with your insurance company, payment is due immediately on co-pays, non-covered services and co-insurance.
5. That it is the responsibility of the policy holder to familiarize themselves with their insurance policy, and its benefits and limitations.
6. That I authorize payment of medical benefits to Grand Parkway Pediatrics for services rendered. I also understand that ultimately I am financially responsible to Grand Parkway Pediatrics for all charges whether or not covered by my insurance carrier.
7. That the information given on this form is complete and accurate.

(Sign below ONLY if this is your child's first visit with our office)

Responsible Party Signature: _____ Relationship to child _____