NEW PATIENT FORM

Today's Date:_____/_____/_____

PARENT #1 _____ DOB _____ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Employer Address _____ EMAIL _____

PARENT #2 _____ DOB _____ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Employer/Occupation _____ Work Phone _____

Employer Address _____ EMAIL _____

Parents are: ❑Married ❑Living Together ❑Separated ❑Divorced If divorced, who is the Custodial Parent: ❑#1 ❑#2

Please see information concerning our yearly administrative fee on attached page. All families with up to date fees automatically enjoy the benefits of our Patient Service Plan. Email you want associated with this plan: _____

Child _____ DOB _____ ❑M ❑F Child _____ DOB _____ ❑M ❑F

Child _____ DOB _____ ❑M ❑F Child _____ DOB _____ ❑M ❑F

Child _____ DOB _____ ❑M ❑F Child _____ DOB _____ ❑M ❑F

Emergency Contact Person _____ Home # _____ Cell# _____

Names of individuals, and relationship, (other than parents) of persons whom I give permission to bring in my child and be responsible for carrying out the directives given to them by **SPACE COAST PEDIATRICS** Please note that the person bringing in the child is responsible for payment.

Name _____ Cell# _____ Name _____ Cell# _____

Who may we thank for referring you to us? _____

Insurance Information (You must provide us with a copy of your current insurance card at every visit)

Insurance Company _____ ID# _____ Eff Date _____

Co-Pay $ _____ Name of Insured _____

Insurance provided through: ❑ Employer ❑Private ❑Other ❑ Self Pay

Name and full address of Employer _____

Please indicate name physician of choice _____

Your preferred Pharmacy _____ Location _____

Authorization of Treatment and Assignment of Benefits:

I authorize Space Coast Pediatrics, to treat my child/children. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to Space Coast Pediatrics for any and all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Space Coast Pediatrics for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments and any charges not covered under my insurance benefits.** I also understand that I am responsible for advising Space Coast Pediatrics of any and all changes to my insurance. **Payment of co-pays are due on date of service.** Failure to pay co-pay at that time will result in an additional billing charge as outline in Financial Policy. Our office requires 24 hours notice of appointment cancellation. Failure to provide this notice will incur a cancellation fee. **PLEASE SEE FINANCIAL POLICY**.

Signature _____ Relationship _____ Date _____

A photocopy or scan of this authorization shall be considered as effective and valid as the original.