

**WELCOME TO LANDEN LAKE PEDIATRICS**

Referred by \_\_\_\_\_

**FATHER'S FULL NAME** \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Business phone (\_\_\_\_) \_\_\_\_\_

**MOTHER'S FULL NAME** \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Business phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION \* WE WILL NEED TO COPY YOUR CARD\***

Primary Insurance Company \_\_\_\_\_ Subscriber \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Subscriber \_\_\_\_\_

**CHILDREN** (please list the first and last name)

Name \_\_\_\_\_ M / F DOB: \_\_\_\_\_

Name \_\_\_\_\_ M / F DOB: \_\_\_\_\_

Name \_\_\_\_\_ M / F DOB: \_\_\_\_\_

Name \_\_\_\_\_ M / F DOB: \_\_\_\_\_

Name \_\_\_\_\_ M / F DOB: \_\_\_\_\_

\*\*\* Please provide us with the name, address and phone number of someone we can contact in case of an emergency--

\_\_\_\_\_

I hereby authorize my insurance benefits to be paid directly to Landen Lake Pediatrics. I also recognize that I am responsible to pay for non-covered services. I hereby authorize the release of pertinent medical information to the above named insurance carrier(s). I also recognize that payment is due at the time of service from whoever accompanies the child (ren) to the appointment.

Signature \_\_\_\_\_ Date: \_\_\_\_\_