WELCOME

Celebration Pediatrics
410 Celebration Place
Suite206
Celebration, FL 34747
407-566-9700

PATIENT INFORMATION

Today's Date ____/____/_____

Child's Legal Name _____

Nickname (if any) _____

Age_____ Date of Birth ____/____/____ Sex _____

Email address for appointment confirmation:

_____

Names of your other children who are patients here

_____

_____

Mother/Legal Guardian's Name

_____

Date of Birth ____/____/____ SS# _____-_____-_____

Home Address _____

_____

City State Zip

Home Phone (____)_____-_____

Cell Phone (____)_____-_____

Place of Employment _____

Work Phone (____)_____-_____ Ext _____

Father/Legal Guardian's Name

_____

Date of Birth ____/____/____ SS# _____-_____-_____

Home Address _____

_____

City State Zip

Home Phone (____) _____-_____

Cell Phone (____)_____-_____

Place of Employment _____

Work Phone (___) _____-_____ Ext _____

How did you hear about our practice?

_____

Who was your obstetrician?

_____

Who if anyone other than the responsible party has permission to be involved in your child's medical treatment including bringing them in for visits?

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to Celebration Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by Celebration Pediatrics and I direct my insurance company to pay any and all such entitlements directly to Celebration Pediatrics.

_____

Parent or Legal Guardian Responsible for Account

I authorize Celebration Pediatrics to render medical care to my child. I understand that all copays and deductibles are to be paid at the time of service. In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection including attorneys' fees. In the event that my child is hospitalized, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to Celebration Pediatrics. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay in payment.

_____

Parent or Legal Guardian Responsible for Account

I have received and understand the attached financial provided to me from Celebration Pediatrics.

_____

Parent or Legal Guardian Responsible for Account

I have received the attached "Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

_____

Parent or Legal Guardian Signature