Silverdale Pediatrics

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PATIENT NAME _____ D.O.B. _____
Last First Middle

Home Phone # _____**Work #** _____ **Cell #** _____

Preferred reminder method (Check one): Call___ Text___ Email_____

Parent or Guardian _____ **SSN#** _____-_____-_____

Occupation _____ Employer _____

Other Parent or Guardian (if Applicable)_____ **SSN#** ____-_____-_____

Occupation _____ Employer _____

Home Address _____

_____
City State Zip

Mailing Address (if different) _____

Is patient an American Indian or an Alaska Native? _____

MEDICAL INSURANCE INFORMATION

Name of Insurance _____ Subscriber _____

SUBSCRIBER SSN:___-___-_____

ID# _____ Group # _____ Subscriber D.O.B._____.

Emergency Contact Name: _____ **Phone**: _____

PATIENT CONSENT INFORMATION

I **agree** to be contacted for routine appointments or follow-up regarding healthcare by phone. Payment is due when service is rendered unless prior arrangements have been made. Please call to cancel or reschedule an appointment by 9 AM the day of the appointment or there is a **$50.00 fee** for a missed appointment. A **$50.00 NSF fee** will be added for all returned checks. I assign my insurance benefits to be paid directly to the physician. Seattle Consulting Nurses charge **$40.00 each**. I agree to be financially responsible for any non-covered services. I authorize the release of any information required to process a claim. In addition, I agree to pay all fees accrued on my account if referred to a collection agency.

_____

Signature of patient or legally authorized individual Date

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____

Signature of patient or legally authorized individual Date