Gold Pediatrics LLC

Patient Registration

Patient Information:

Last Name:_____ First Name:_____ MI:_____

Sex: M/F Date of Birth:_____ Race: _____ Ethnicity: _____ Language: _____

Street Address:_____

City:_____ State: _____ Zip Code:_____ Phone: _____

Parent/Guardian 1 Information: Relationship to patient: □Mother □Father □Other:_____

Last Name:_____ First Name:_____ MI:_____

Sex: M/F Date of Birth:_____ SS#:_____ Email:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Cell#:_____ Home#:_____ Work#: _____ Ext: _____

Preferred Method of Contact for Appointment Reminders: □call to home □call to cell □text to cell □email

Parent/Guardian 2 Information: Relationship to patient: □Mother □Father □Other:_____

Last Name:_____ First Name:_____ MI:_____

Sex: M/F Date of Birth:_____ SS#:_____ Email:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Cell#:_____ Home#:_____ Work#: Ext:_____

Preferred Method of Contact for Appointment Reminders: □call to home □call to cell □text to cell □email

Primary Insurance Information: Insurance Company Name:_____

Policy ID #:_____ Group #: _____ Name of Insured:_____

SS# of Insured:_____ Relationship to Patient: _____ Address of Insured: □ Same as Patient

Street Address of Insured:_____ City, State, Zip:_____

Cell#:_____ Home#:_____ Work#:_____ Ext:_____

Method of Contact: □Cell □Home □Work

Secondary Insurance Information: Insurance Company Name:_____

Policy ID #:_____ Group #: _____ Name of Insured:_____

SS# of Insured:_____ Relationship to Patient: _____ Address of Insured: □ Same as Patient

Street Address of Insured:_____ City, State, Zip:_____

Cell#:_____ Home#:_____ Work#:_____ Ext:_____

Method of Contact: □Cell □Home □Work

Emergency Contact Information:

Contact Name:_____ Cell#:_____ Home#:_____

Relationship to Patient:_____ Comment:_____

Additional Patients/Sibling Information

Name:_____ Date of Birth:_____ Sex: M/F

Name:_____ Date of Birth:_____ Sex: M/F

Name:_____ Date of Birth:_____ Sex: M/F

Name:_____ Date of Birth:_____ Sex: M/F

How did you hear about Gold Pediatrics LLC? _____

Assignment of Benefits/Insurance/Financial Responsibility

I understand that it is my responsibility to know my insurance and the benefits covered by my insurance. It is also my responsibility to provide current/valid insurance at every visit. Any disclosure to changes to my insurance such as termination, change in order of insurance coverage (primary and secondary), addition of secondary insurance, etc. are my responsibility. I understand that I am financially responsible to Gold Pediatrics LLC for any and all charges associated with the services rendered by Gold Pediatrics LLC. This is true whether through a self-pay arrangement or assignment of applicable medical benefits under which I am a covered beneficiary. Gold Pediatrics LLC verifies insurance benefits, however exact coverage/benefits cannot be determined until the claim is received and reviewed by my insurance carrier. Any verification of benefits done by Gold Pediatrics is a quoted benefit from my insurance company. I understand this is not a guarantee of payment from an insurance carrier, and all benefits are subject to the conditions and limitations of my plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits, or for charges which the insurance carrier declines to pay.

Appointment Cancellation/No-Show Policy

If you cannot keep an appointment, please call the office to notify us immediately so we can give this time to another patient. Failure to do so will result in a $50 charge for well visits and $25 charge for sick/ established patient visits. Continued or multiple No-Show appointments may result in discharge from the practice.

Form Fee:

There will be a $10 fee for school or daycare forms effective 1/2/2023.

Signature Required

The undersigned acknowledges that they have read and understand the above terms and conditions.

_____ _____

Parent/Guardian/Guarantor Printed Name

Parent/Guardian/Guarantor Signature

_____

Date