BAKER PEDIATRICS
PARTNERSHIP WITH FAMILIES

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CHILD'S NAME_____**DOB/SEX**_____**M OR F**

HOME ADDRESS_____

CITY/STATE/ZIP CODE_____

HOME TELEPHONE NUMBER_____

Primary EMAIL :_____(needed for access to your child's records via out website)

REFERRED BY_____

PHARMACY_____

PARENT NAME_____**PARENT NAME**_____

ADDRESS: _____**ADDRESS:**_____

CITY_____**STATE/ZIP**_____**CITY**_____**STATE/ZIP**_____

CELL #_____**WORK #**_____**CELL #**_____**WORK #**_____

EMPLOYER: _____ **EMPLOYER** _____

INSURANCE INFORMATION (PLEASE PRESENT CARD)

PRIMARY POLICY HOLDER_____**INSURANCE CO.**_____

POLICY #_____**GROUP #**_____

RELATIONSHIP TO PATIENT_____

I understand that is my responsibility to pay deductibles, co-insurances, copayments or any other balance that is deemed a non-covered service by insurance company. I understand that I am responsible for any costs incurred in the collection of my account in case of default. I hereby grant permission to Baker Pediatrics, LLC to release pertinent information to my insurance company upon request and I also authorize payment directly to Baker Pediatrics, LLC. A photo static copy of this authorization shall be considered as effective and valid as the original. If I am more than 20 minutes late for an appointment I may have to be rescheduled.

Print name & Sign_____**Date**_____