



OLDHAM COUNTY PEDIATRICS, PLLC

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PATIENT INFORMATION

Patient Full Name: _____
(Last) (first) (MI) "Call me"

Date of Birth: _____ Gender: Male / Female SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Alternate Phone#: _____

Parents' Names: _____

Siblings: _____

Emergency Contacts	Phone #'s	Relationship to Patient
1. _____	_____	_____
2. _____	_____	_____

Guarantor/Responsible Party Information

Guarantor: _____ Relationship to patient: _____

Guarantor's Date of Birth: _____ Social Security #: _____

Address: _____ City _____ State _____ Zip _____

Guarantor's Employer: _____ Phone: _____

Primary Insurance Information

Insurance Company: _____

Insurance Co. Address: _____ City _____ State _____ Zip _____

Insurance Co. Phone #: _____

Policy Owner: _____ Relationship to Patient: _____

Policy Owner's Date Of Birth: _____ Social Security #: _____

Secondary Insurance? _____

I authorize the release of medical information needed to determine any benefits under my insurance policy. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. I have read and agree with the Oldham County Pediatrics vaccination policy. I have received the privacy statement of Oldham County Pediatrics. I consent to routine treatment and procedures provided by Oldham County Pediatrics, PLLC, and understand that no guarantee of result has been made.

Signature: _____

Date: _____