Building Blocks Pediatrics

Central Ohio Primary Care Physicians, Inc

Please fill out this form and return it to the front desk before continuing with other paperwork. Thank you.

TODAY'S DATE ____/____/_____ Doctor (circle one) Budin Campbell Orr Perry Stiles

Children Please list all children and their dates of birth. Begin with the oldest.

Child's name	**Birthdates**	**Child's name**	**Birthdates**
_____	M / F _____	_____	M / F _____
_____	M / F _____	_____	M / F _____
_____	M / F _____	_____	M / F _____
_____	M / F _____	_____	M / F _____

Guarantor Mother Father Guardian Other _____
(person responsible for payment)
Name_____,_____,_____
LAST FIRST MIDDLE
Address _____
City, State_____ Zip_____
Home Phone ( )_____Cell ( )_____
Work Phone ( ) _____ Ext_____
Guarantor SSN_____-_____-_____
Guarantor Date of birth _____/_____/_____
Employer _____
Occupation_____
Emergency Contact_____Relationship_____
Emergency ( ) _____ Ext _____

Insurance
Primary Insurance Company _____
Policy Holder (usually an adult) _____
Policy Holder DOB _____/_____/_____
Policy Number _____
Group Number _____

Secondary Insurance Company_____
Policy Holder (usually an adult) _____
Policy Holder DOB _____/_____/_____
Policy Number _____
Group Number _____

Other Adults Mother Father Guardian Other _____
Name_____,_____,____
LAST FIRST MIDDLE
Date of birth ____/____/____ SSN_____-_____-_____
Address_____
City, State_____ Zip_____
Home( ) _____ Work( )_____
Cell ( ) _____
Employer_____
Occupation_____

Other Adults Mother Father Guardian Other _____
Name_____,_____,____
LAST FIRST MIDDLE
Date of birth ____/____/____ SSN_____-_____-_____
Address_____
City, State_____ Zip_____
Home( ) _____ Work( ) _____
Cell ( ) _____
Employer_____
Occupation_____

INSURANCE PAYMENT CONSENT

I understand that my insurance carrier can choose to assign benefits to Central Ohio Primary Care Physicians or my insurance carrier may make payment directly to me. I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier, as well as for any applicable co-payment, co-insurance, deductible, or charges for non-covered services provided to me or to any of my dependents. I am also responsible for providing up to date accurate insurance information.

Medicare and Medicaid I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers any and all information needed for this or a related Medicare or Medicaid claim.

Guarantee of payment: By signing below, I certify that I will pay to Central Ohio Primary Care Physicians, any co-payments, co-insurance, deductibles, or non-covered services. I will immediately pay to Central Ohio Primary Care Physicians any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance for my failure to provide the appropriate insurance information for billing.

Name_____ Date_____
(Printed)
Signature_____ _____ Witness_____
(If patient is 18 years or older, his/her signature is required in addition to the responsible party)