Blackstone Valley Pediatrics

Patient Information

Patient Name: _____ **Date of Birth:**_____

Address: _____

Primary Number:_____ **Email**:_____

Race (check all that apply): ___Asian ___African American/Black ___Caucasian/White

___Hispanic ___Other ___Decline

Ethnic Group: ___Non Hispanic/Latino ___Hispanic/Latino ___Decline

Guardian Information

Name: _____ **Relation:** _____ **Date of Birth:** _____

Phone Number: _____ **Secondary Number:** _____

Name: _____ **Relation:** _____ **Date of Birth:** _____

Phone Number: _____ **Secondary Number:** _____

***Preferred Reminder Notifications: (Check One)** ___ **Phone Call** ___ **Text Message**
(Will be sent to Primary Number)

Insurance Information

Insurance Company:_____ **Policy #:** _____ **Group #**_____

Subscriber Name: _____ **Subscriber DOB:**_____

Secondary Insurance Company: _____ **Policy #:** _____**Group #** _____

Subscriber Name:_____ **Subscriber DOB:** _____

Pharmacy Name & City: **Phone Number:**

I understand that I am responsible for paying directly any applicable deductible/copayment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier and seek alternative methods of collection. Failure to meet my financial obligations is a violation of my agreement/contract with my insurance carrier. I also understand that if I have unpaid deductibles or copayments owed to my provider longer than 90 days, my provider may terminate the doctor/patient relationship as a result, subject to the requirements of state and/or federal law.
I understand that my insurance card is required at each visit and if my insurance is not in effect at the time of visit, I understand that I am responsible for payment.

I have read the HIPAA medical information disclosure and understand the above.

Guardian Signature: _____ **Date:** _____

Signed off by: _____ **(Office Staff Only)**