Focus on Kids Pediatrics
9200 W Cross Drive, Suite 100
Littleton, CO 80123
Ph 303-972-7337/Fax 303-972-0026
www.focusonkidspeds.com
office@focusonkidspeds.com

PLEASE NOTE: We will be unable to bill your insurance if we do not receive this paperwork back completed in its entirety and have a copy of your current insurance card on file.

DATE _____

PATIENT INFORMATION:

Child's Legal Name _____Date of Birth_____ Sex Male / Female

Child's Legal Name _____Date of Birth_____ Sex Male / Female

Child's Legal Name _____Date of Birth_____ Sex Male / Female

Child's Legal Name _____Date of Birth_____ Sex Male / Female

Child's Legal Name _____Date of Birth_____ Sex Male / Female

Race_____ Ethnicity Hispanic / Not Hispanic

Primary Phone _____Home / Cell Alternate Phone _____Home / Cell

Primary Address_____City_____State_____Zip_____

Preferred Method of Communication: TEXT MESSAGE or VOICE MESSAGE

PARENT/GUARDIAN INFORMATION:

Guardian's Name_____ Relationship to patient _____

Date of Birth _____Is this person an authorized medical decision maker for the patient? Yes / No

Primary Phone Number _____Home/Cell? Email Address_____

Address (If different from patient) _____City_____State_____Zip_____

Employer_____Work Phone_____

Spouse's Name _____Phone Number_____

Guardian's Name_____ Relationship to patient _____

Date of Birth _____Is this person an authorized medical decision maker for the patient? Yes / No

Primary Phone Number _____Home/Cell? Email Address_____

Address (If different from patient) _____City_____State_____Zip_____

Employer_____Work Phone_____

Spouse's Name _____Phone Number_____

EMERGENCY CONTACT (NOT LIVING IN HOME) _____PHONE NUMBER_____

AUTHORIZATION FOR TREATMENT: I (we) give the following people permission to bring our child(ren) in and to consent for treatment (i.e., grandparent, nanny, etc.).

Name_____ Relationship to Patient _____Initials_____

Name_____ Relationship to Patient _____Initials_____

Name_____ Relationship to Patient _____Initials_____

CONTINUED ON OTHER SIDE

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FINANCIAL INFORMATION

INSURANCE INFORMATION: ***IN ORDER TO BILL INSURANCE, THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY***

Primary Insurance_____Effective Date_____

Insurance ID Number_____ Group Number_____

Subscriber/Policyholder Name _____Date of Birth_____

Relationship to patient_____ Address (if different from patient) _____

Secondary Insurance _____Effective Date_____

Insurance ID Number_____ Group Number_____

Subscriber/Policyholder Name _____Date of Birth_____

Relationship to patient_____ Address (if different from patient) _____

My signature indicates that I have provided the most accurate information to the best of my ability.

Signature of patient/parent/legal guardian_____Date_____

DO NOT SIGN BELOW UNLESS INSTRUCTED TO DO SO BY A STAFF MEMBER:

I have reviewed the above demographic and insurance information and confirm that all information is still current.

Date _____ Signature _____

Relation _____

For Employee Use: Verified/Updated on _____ Initials _____

Date _____ Signature _____

Relation _____

For Employee Use: Verified/Updated on _____ Initials _____

CONTINUED ON OTHER SIDE