Village Pointe Pediatrics, P.C.

In order for us to serve your health care needs, please provide us with your family's information.
All information is kept confidential.
Thank you for choosing our office!

CHILDREN'S INFORMATION

Last:	First:	MI:	Boy___ Girl___	DOB: / /
Address:	City:	State :	Zip:	
Childs Home Phone: Parent Cell Phone:	Emergency contact outside of your home: Name: Phone: Relationship to Patient:			
Pediatrician: Anderson Belin Byrne Cohen Davey Dek Larson Steinauer				

LIST SIBLING INFORMATION BELOW ** Children under 18 years of age that currently come to our office **

Name MI (last name if different)	DOB	M/F	Name MI (last name if different)	DOB	M/F
1.			3.		
2.			4.		

~~~~~~~~~~~~~~~~~~~~~Parent or Guardian Information~~~~~~~~~~~~~~~~~~~~~

Mother / Guardian circle one	Father / Guardian circle one
Last: First: MI:	Last: First: MI:
DOB: ____/____/____ SS# / /	DOB:____/____/____ SS# / /
Employer: Work Phone: ( )	Employer: Work Phone: ( )
Home Phone: ( ) Cell Phone: ( )	Home Phone: ( ) Cell Phone: ( )
___ if address is the same as above check here Address: City: State: Zip:	___ if address is the same as above check here Address: City: State: Zip:

Medicaid Information	Private Insurance Information
_____ Yes, I am covered by NE Medicaid. _____ Yes, I am covered by IA Medicaid. _____ NO, I am not covered by either Medicaid program. ***Please fill out insurance info in the column to the right.	Insurance Name: Policy Holder Name: Employer who furnishes the policy: _____ I am not covered by insurance at this time.

Financial Responsibility I am aware that I am responsible for any outstanding balance whether or not paid by above insurance or pending insurance claim. I authorize payment of insurance benefits directly to Village Pointe Pediatrics and in the event these payments are made directly to the undersigned, the payee will endorse all checks to Village Pointe Pediatrics for such payment.
I acknowledge receipt of Village Pointe Pediatrics Notice of Privacy Practices as set forth by the Health Information Portability and Accountability Act (HIPAA) at this visit and at any future visits.

Consent to Treatment I, the parent/authorized guardian, give Village Pointe Pediatrics consent to administer care/treatment for my child(ren) from the pediatricians and other health care providers employed by Village Pointe Pediatric, P.C.

Parent/Guardian Signature: _____ Date: _____

My signature certifies that I have read, understand and accept the terms of the above.
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