_____Village Pointe Pediatrics, P.C. /_____ Dundee Pediatrics

**Child's Information** **Billing:** **Front Desk:**

| | | | | |
|---|---|---|---|---|
| Last: | First: | MI: | Boy____ Girl____ | DOB: / / |
| | | | | New Patient check here: _____ |
| Address: | City: | State: | Zip: | |

ONLY list names of children living in your home full time who are under the age of 19 years.

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

Doctor __K. Anderson __J. Andresen __Belin __Byrne__Christner __Coffey __Cohen__Davey __ Dek __ Larson ___Steinauer

Primary E-mail address:

Only ONE email address, this will be used for our records portal.

| Parent: ____ MOTHER _____ Father Or _____ Guardian | Parent: ____ FATHER ____Mother Or _____ Guardian |
|---|---|
| Last: First: MI: | Last: First: MI: |
| DOB: / / SSN: / / | DOB: _____/_____/_____ SSN: / / |
| Cell Phone : ( ) Land Line: ( ) | Cell Phone ( ) Land Line ( ) |
| Employer: Work Phone: ( ) | Employer: Work Phone: ( ) |
| ___check if home address same as above, if not fill in below Address: City: State: Zip: | ____ check if home address same as above, if not fill in below Address: City: State: Zip: |

Emergency contact outside your home: Name:_____ Phone: _____ Relationship:_____

Person(s) responsible for medical bills if NOT at same home address ____Both Parents ____ Father OR ____ Mother

| Medicaid or Self Pay Information | Insurance Information |
|---|---|
| _____ Yes, I am covered by NE Medicaid.<br>_____ Yes, I am covered by IA Medicaid.<br>_____ I am pending Medicaid.<br>_____ I am not covered by insurance at this time. | Primary Insurance Name:_____<br>Policy Holder: ____ Father _____ Mother____ Guardian<br>Secondary Insurance Name:_____<br>Policy Holder: ____ Father _____ Mother____ Guardian |

**Financial Responsibility:** I am aware that I am responsible for any outstanding balance whether or not paid by my insurance. I authorize payment of insurance benefits directly to Village Pointe Pediatrics, P.C. or Dundee Pediatrics. I understand that it is my responsibility to know my insurance benefits and coverage.

**HIPAA:** I acknowledge receipt of Notice of Privacy Practices as set forth by the Health Information Portability and Accountability Act (HIPAA) at this visit and at any future visits. I authorize Village Pointe Pediatrics or Dundee Pediatrics to release any of my or my dependent's medical or personal information for evaluation, treatment, consulting, and processing of insurance benefits.

**Authorization to Mail, Call or E-mail:** I authorize Village Pointe Pediatrics or Dundee Pediatrics representative to leave messages on my voicemail, answering machine and e-mail with communication, including but not limited to appointment reminders, referral arrangements, and balance notices.

**Prescription History:** I authorize Village Pointe Pediatrics to view my external prescription history via Surescripts prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

**Consent to Treat:** I, the parent/authorized guardian, give Village Pointe Pediatrics or Dundee 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. or Dundee Pediatrics.

Parent/Guardian Signature: _____ Date: _____

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