

Siblings:

Name: _____ DOB _____ Sex: M / F
 Name: _____ DOB _____ Sex: M / F
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Person to contact in case of emergency (other than parents): _____

Relationship: _____ Phone: _____

PREFERRED PHARMACY: _____ PHONE: _____

Insurance information:

Company: _____ Group No: _____
 Subscriber ID: _____ Co-pay: _____ Ded. Amount: _____
 Insured Name: _____ DOB _____ SSN: _____
 Employer: _____

Payment is due at the time services are rendered. This includes applicable coinsurance and copayments for participating insurance companies. We file primary insurance only!

✓ I hereby authorize Legacy Pediatrics to furnish information to any insurance carrier, physician, attorney or employer concerning my child's medical history, illness and treatment and hereby assign to the physician(s) all payments for medical services rendered to my dependants or myself. I also authorize any physician, hospital insurance carrier or employer to release any information concerning my child's medical history, illness and medical treatments to Legacy Pediatrics.

- € I have received a copy of *Legacy Pediatrics* Notice of Privacy Practices.
- € I consent to medical treatment necessary for the above patient.

Signature of legal guardian/relationship

Date