Patient's Name: ____ DOB: ________________

Mother's Place of Employment/Occupation: ____

Workplace Phone #: (   ) ____________________ Ext. _______

EMERGENCY CONTACT

Name of person to be contacted in case of emergency (other than those listed above):

Name: ___________________________________ Relationship: _____________________

Address: ________________________________ Phone #: (   ) _______________________

INSURANCE INFORMATION (Please provide insurance card for chart copy).

Name of Insurance Carrier/Plan: ____

Claims Address: ____

____

Phone # (   )_____________________ Is this plan provided by your employer? Yes or No

Policy Holder's Name: ________________________________ DOB: ________________

Type of Plan? HMO PPO Other Effective Date of Coverage: _________________

Group #: __________________________ ID: ____________________________________

Amount of Co-Pay: Primary Care Physician: _______________________

PHARMACY NAME: _________________**Phone #**: (   ) _______________________

I hereby give consent to Pediatric Gastroenterology of Central Florida to provide whatever treatment the assigned physician may deem necessary to the patient named above.

I understand I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Pediatric Gastroenterology of Central Florida for professional physician's fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by the insurance policy, including copayments and deductibles.

Parent's/Guarantor Signature: _________________________ Date: _____________________