Complete Pediatrics, P.C.

Please fill out this form entirely.

Patient Information:

Last Name:_____**First Name:**_____**MI:**_____**Gender:**_____**DOB:**_____

Last Name:_____**First Name:**_____**MI:**_____**Gender:**_____**DOB:**_____

Address:_____

City:_____**State:**_____ **Zip Code:**_____

Parent 1 Name:_____ **Phone:**_____ ○ **(Best # to Confirm Text Appt. Messages)**

Parent 2 Name:_____ **Phone:**_____ ○ **(Best # to Confirm Text Appt. Messages)**

Patient Personal Phone (If Applicable):_____ ○ **(Best # to Confirm Text Appt. Messages *18 & above ONLY)**

PCP:_____

Email Address: _____

***Emergency Contact (Other Than Parents):** _____ **Relationship To Patient:**_____

Race: (Please Check)

- ☐ Caucasian
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other Race:_____

Languages Spoken:_____

Ethnicity: (Please Check)

- ☐ Hispanic
- ☐ Non-Hispanic

Insurance Information:

Primary Insurance:

Insurance:_____Policy ID:_____Group ID:_____

Policy Holder:_____DOB:_____Relationship:_____

Secondary Insurance:

Insurance:_____Policy ID:_____Group ID:_____

Policy Holder:_____DOB:_____Relationship:_____

Guarantor (Person to be billed)

Last Name:_____First Name:_____MI:_____

Gender:_____Relationship:_____Birth Date:_____

Address (If different from patient):_____ City:_____

State:_____ Zip Code:_____Phone Number:_____

Email Address:_____ ☐ Patient ☐ Parent ☐ Other:_____

Employer Name:_____Occupation:_____

Patient or Authorized Person's Signature:

I, the undersigned, give my authorization to treat and assign directly to Complete Pediatrics, P.C. (COPE, P.C.) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for the payment of any deductible amounts, coinsurance, or other expenses not paid by insurance, as well as any administrative costs such as missed appointments, rebilling fees, and expenses incurred in attempting to collect balance not paid at time of service. I also understand payment is expected and due at time of service.

I hereby authorize COPE, PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: Signature Date:

X_____ _____

Please provide current copy of insurance cards at each visit. Thank you.