PATIENT INFORMATION

Patient Name:_____ SS# _____
Date of Birth :_____ Sex _____
Address: _____ City: _____ Zip _____
Home phone ( ) _____ Cell Phone ( ) _____ other ( ) _____
E-mail_____

Pharmacy Preference (Name and address): _____
Who should we thank for referring you to us? _____

Employer: _____ Phone: ( ) _____
Address: _____ City: _____ Zip _____

Responsible party/Guardian
Name _____ Relationship _____
Address: _____ City: _____ Zip _____
Phone: ( ) _____ Date of birth _____SS# _____ Sex _____
Primary Insurance carrier : _____
Policy holder's name: _____ Date of Birth: _____
Employer: _____ Employer's phone: _____
Group # _____ Policy or ID# _____
Insurance company address _____
City: _____ State: _____ Zip: _____
Secondary Insurance carrier : _____
Policy holder's name: _____ Date of Birth: _____
Employer: _____ Employer's phone: _____
Group # _____ Policy or ID# _____
Insurance company address _____
City: _____ State: _____ Zip: _____

Emergency Contact
Name _____ Relationship _____
Address: _____ City: _____ Zip _____
Phone: ( ) _____

You have to provide copies of your current Insurance card(s) & Drivers License photo ID. We reserve the right to refuse treatment if these Items are not provided; we also reserve the right to refuse treatment to those persons who use vulgarity or threats to staff or physicians.
AUTHORIZATION TO PAY BENEFITS TO FACILITY: I hereby authorize payment directly to Best Care Pediatrics. Not to exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed private insurance carrier payment and if greater than such payment I will be held responsible for that amount.

Signature_____ Date_____

Best Care PEDIATRICS
Keeping Kids Growing Healthy

4220 S. 27th Street, Suite #200
Milwaukee, WI 53221
Phone: 414-282-5810
Fax: 414-282-5468
www.bestcarepeds.com
sgarzon@bestcarepeds.com