Southeast Denver Pediatrics, P.C.

2121 S. Oneida, Ste. 200 • Denver, Colorado 80224-2551 303 • 757-6418 • FAX 303 • 757-2209
11960 Lioness Way, Suite 200 • Parker, Colorado 80134 303 • 471-5060 • FAX 303 • 471-5062

PLEASE INCLUDE ALL INFORMATION

Children:	Last Name	First Name	MI	Birthdate	Sex

Primary Care Physician: ☐ Hand ☐ Sagel ☐ Tucker ☐ Schwartz ☐ Miga ☐ Carlson ☐ Erdley

Name of Friend/Relative/Emergency Contact: ____________________

Phone: ____________________ Address: ____________________

☐ Father ☐ Mother ☐ Other/Relationship __________
Insurance Subscriber ☐ Person Responsible for Bill ☐
Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone : __________ Birthdate: __________
Driver's License #: ____________________State: ______
Social Security #: ____________________
DAYTIME/CELL PHONE: ____________________
Employer: ____________________
Address: ____________________
City, State, Zip: ____________________
Work Phone #: ____________________ Ext.: ______

☐ Father ☐ Mother ☐ Other/Relationship __________
Insurance Subscriber ☐ Person Responsible for Bill ☐
Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone : __________ Birthdate: __________
Driver's License #: ____________________State: ______
Social Security #: ____________________
DAYTIME/CELL PHONE: ____________________
Employer: ____________________
Address: ____________________
City, State, Zip: ____________________
Work Phone #: ____________________ Ext.: ______

INSURANCE INFORMATION

Primary Insurance Co. Name: ____________________ Copay: __________
Subscriber Name: ____________________ ID/SSN#:__________
Group (GRP): ____________________
Insurance Company Address: ____________________

Secondary Insurance Co. Name: ____________________ Copay: __________
Subscriber Name: ____________________ S.S./Subscriber #:__________
Group #:____________________
Insurance Company Address: ____________________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to Southeast Denver Pediatrics for services rendered. I understand that I am financially responsible for any balance not covered by insurance.

Date: ____________________ Signature: ____________________

Relationship to Patient: ____________________

PATIENT INFO 2/09