Littleton Pediatric Medical Center
206 W. County Line Rd. STE 110
Highlands Ranch, CO 80129

PATIENT AND HEALTH INSURANCE INFORMATION

RESPONSIBLE PARTY RESPONSIBLE PARTY RESPONSIBLE PARTY

NAME: CELL PHONE: HOME PHONE:

_____

ADDRESS: _____

CITY _____ STATE _____ ZIP CODE _____

NAME OF INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

POLICY HOLDER EMPLOYER: _____ WORK PH: _____

MEMBER ID#: _____ POLICY GROUP#: _____

EFFECTIVE DATE OF NEW POLICY: _____ ***TERM DATE OF PREVIOUS POLICY:*** _____

LIST ALL CHILDREN AND THEIR DATE OF BIRTH COVERED UNDER NEW HEALTH INSURANCE

_____ _____ _____

_____ _____ _____

In the day and age of technology, many of our patients appreciate a text or email appointment reminders. Do we have your cell# and email address?

Text Cell#: _____ **Email:** _____

I hereby grant my healthcare provider permission to contact me via an automated phone/text/email system. I authorize my healthcare provider to disclose to third parties who answer my phone or have access to my communications my limited protected health information, and to leave a message on these devices.

In that my son/daughter is a minor (less than eighteen (18) years of age and primarily supported by parent or guardian), I agree and understand that he/she may be treated by any physician associated here. This may include physical and laboratory tests, minor surgery, immunizations and prescription medications in my absence. Littleton Pediatric Medical Center (LPMC) has my consent to leave messages pertaining to my child's clinical care or account information on designated answering machine, voice mail or fax number. This agreement will be in effect until revoked by me in writing. If for some reason the coverage with my insurance company is not effective for the above person(s), I agree to pay for any charges incurred in this office. When applicable, I authorize LPMC to file insurance claims.

RELATIONSHIP TO PATIENT: _____ **DATE:** _____

SIGNATURE: _____