Northwoods Pediatric Center
(Please Print Clearly)

Patient's Name_____Date of Birth_____Sex_____

Address_____City & Zip_____

Home Phone#_____

Mom's Information

Mom's Name_____SS#_____DOB_____

Employer_____WK#_____Cell#_____

Dad's Information

Dad's Name_____SS#_____DOB_____

Employer_____WK#_____Cell#_____

Medical Insurance Information

Aetna___ Blue Cross/Blue Shield___ Cigna___ Humana___ Memorial Hermann___ Unicare___
United Healthcare___ PHCS___ CHIP___ Other_____

Policy Holder

Who is the policy holder? Dad____ Mom____ Child's individual policy____

Emergency Contacts

Name_____Home ph#_____Cell#_____

Nearest Relative (not living with you)

Name_____Home ph#_____Cell#_____

Authorizations

I authorize the following persons to bring my child for well/sick health care visits at Northwoods Pediatric Center, and receive lab/x-ray results in my absence:

1._____2._____3._____

_____-I authorize Northwoods Pediatric to leave my child's lab/x-ray results on my home/cell Phone if I cannot be reached.

_____-I **do not** authorize Northwoods Pediatric to leave my child's lab/x-ray results on my Home/ cell phone if I cannot be reached.

By signing below you authorize Northwoods Pediatric to treat the above patient and also authorize payment of medical benefits, release of correspondence and/or medical records to other medical providers involved in your child's care. I have also read and understand the Northwoods Pediatric Financial Policy.

_____ _____

Parent/Guardian's Signature Date (rev 5/10)