WELCOME TO GREEN MOUNTAIN PEDIATRICS

Date: ______________________

Patient Name:
Last _____________________ First __________________ Middle _____________
(Please Print)
Address: _____________________________ Apt #__________ City ____________

State ______ Zip Code_______ Home Phone # ___________ Cell # _____________

Email Address: ____

Date of Birth: __________________ Sex: F___, M ____

Mothers Name: _________________________________ SS#______________________
Address: _______________________________________ Phone #__________________
(If different)
Place of Employment: ____
Work Address: __________________________________ Work Phone______________

Fathers Name: ___________________________________ SS#_____________________
Address: ____ Phone #_________________
(If different)
Place of Employment: ____
Work Address: ___________________________________ Work Phone_____________

Insurance Information:
Primary Insurance __________________________ Effective Date _________________
Primary Insured Name ______________________ID #__________Policy #__________
Secondary Insurance__________________________ Effective Date_________________
Secondary Insured Name ___________________ID #____________ Policy #_________

Emergency Contact Name: ___________________________ Phone # _______________

I authorize payment of medical benefits to physician or supplier for these services and all future claims. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and cost of collection in the event of default. I understand that I may be charged $30 for each missed appointment that was not cancelled prior. I also understand that I may be charged $30 for each applicable co-payment not made at the time of service. I authorize the release of any medical information necessary to process this claim and all future claims.

Signature ________________________________ Date: __________________________
(Parent or Guardian if Patient of Minor)