

# BALLARD PEDIATRIC CLINIC

This form MUST be updated annually  
Please print clearly and answer completely!

## PATIENT INFORMATION

NAME (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last) \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ SSN: \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ GENDER  MALE  FEMALE  
WHO REFERRED YOU TO US? \_\_\_\_\_ PHONE \_\_\_\_\_  
PERSON TO CONTACT (other than below) FOR EMERGENCY \_\_\_\_\_  
NAME PHONE

## 1 PARENT INFORMATION Mother Father Other (guardian, foster parent, etc.)

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_  
(if different from above)  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
(if different from above)  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ POLICY HOLDER FOR PATIENT?  Yes  No

## 2 PARENT INFORMATION Mother Father Other (guardian, foster parent, etc.)

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_  
(if different from above)  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
(if different from above)  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ POLICY HOLDER FOR PATIENT?  Yes  No

## INSURANCE INFORMATION

NAME OF INSURANCE COMPANY \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_  
SUBSCRIBER'S NAME \_\_\_\_\_ SUBSCRIBER'S SOCIAL SECURITY # \_\_\_\_\_  
INSURANCE GROUP # \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_  
DOES YOUR INSURANCE REQUIRE PRE-AUTHORIZATION FOR REFERRALS?  Yes  No

## ADDITIONAL INFORMATION

DO YOU HAVE SECONDARY INSURANCE?  Yes  No  
IF YES, IS COVERAGE PROVIDED BY:  MEDICAID/DSHS  OTHER \_\_\_\_\_  
(Name of insurance carrier)  
WITH WHOM DO THE CHILDREN LIVE? \_\_\_\_\_  
OTHER CHILDREN (including last name if different)  
NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the physicians of Ballard Pediatric Clinic, Inc. I also authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account.

The above information is complete and accurate to the best of my knowledge.

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_