PATIENT INFORMATION

First Name________________________________ Middle Initial__________
Last Name________________________________
Address__________________________City____________State______Zip________
Date of Birth______________________ SS#____________________________
Sex (circle one) Male/Female

MOTHER/GUARDIAN INFORMATION

First Name________________________________ Middle Initial__________
Last Name________________________________
Address__________________________City____________State______Zip________
Home#__________________ Cell# ______________ Work#__________________
Preferred# ______________________________
Date of Birth__________________ SS#____________________
E-Mail______________________
Employer______________________________________
Marital Status (circle one) Married Single Divorced Widowed Separated

FATHER/GUARDIAN INFORMATION

First Name________________________________ Middle Initial__________
Last Name________________________________
Address__________________________City____________State______Zip________
Home#__________________ Cell#______________ Work#__________________
Preferred#______________________________
Date of Birth__________________ SS#____________________
E-Mail______________________
Employer______________________________________
Marital Status (circle one) Married Single Divorced Widowed Separated

PRIMARY INSURANCE INFORMATION

Name of Insurance Company____
Name of Insured________________________ Relationship to patient________
Insured Member's SS#__________________DOB______________
Insured Member's Employer____
Policy#____________________________ Group#__________________
Effective Date__________________

SECONDARY INSURANCE INFORMATION

Name of Insurance Company____
Name of Insured________________________ Relationship to Patient________
Insured Member's SS# __________________DOB______________
Insured Member's Employer____
Policy #____________________________Group #__________________
Effective Date__________________

OTHER CHILDREN

Name_____________ DOB__________ Name_______________ DOB__________

Name_____________ DOB__________ Name_______________ DOB__________

EMERGENCY CONTACT INFORMATION

Please list someone for us to call in the event of an emergency:

Name____ Phone Number____________

Relationship to Patient____

OTHER AUTHORIZED PERSON

Please list anyone other than parent who can bring this child into our office for medical treatment:

Name____________________________________ Relationship________________

Name____________________________________ Relationship________________

FINANCIAL OBLIGATION

I understand that I am ultimately responsible for all charges incurred on behalf of my minor child or the child who is seeking medical care while in my custody. Any co-pays, deductibles, or charges which are denied coverage from my commercial insurance company are my responsibility and will be paid at the time they are incurred.

Signature of Person Completing Form: _____________________________

Print Name: ____________________________________ Date: __________________

☐ I have been given an opportunity to receive HIPAA information for this practice.

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to Lifeguard Pediatrics, PC of all medical/surgical/major medical benefits to which I am entitled under any insurance policy or policies, under any self-insurance program or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility, including, but not limited to payment of those fees and charges not directly reimbursed to Lifeguard Pediatrics by any insurance policy, self-insurance plan or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

______________________________	____________
Person Providing Authorization	**Date**
______________________________	______________________
Patient's Name	**Relationship to Patient**

PATIENT ELIGIBILITY SCREENING RECORD
VACCINE FOR CHILDREN PROGRAM

This provider participates in the Vaccines for Children Program(VFC). If you meet the requirements of this program, we can provide your child's immunizations at a reduced fee. In order to determine eligibility, we must know if your child has insurance that pays for immunizations.

Date ______________________________

Child ____
Last Name First Name MI

Date of Birth ____________________
MM/DD/YYYY

Parent/Guardian____
Last Name First Name MI

Provider/Physician: Kevin Niebaum, DO

INELIGIBLE FOR STATE SUPPLIED VACCINE (check if applicable)

The child has insurance that pays for immunizations. ☐
(Fully-insured/Private pay)

ELIGIBLE FOR STATE SUPPLIED VACCINE

This child qualifies for vaccination with state-supplied vaccine because he/she (check only one box)

(a) is enrolled in Medicaid ☐ or

(b) is an American Indian or Alaskan Native ☐ or

(c) does not have Health Insurance*(not insured)* ☐ or

(d) has Health Insurance that does not pay for vaccines ☐ or
(Underinsured)

(e) is enrolled in Peachcare for Kids ☐

NOTE TO PROVIDERS:
A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with avaccines suuplied by state programs. The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. This same record may be used for all subsequent visits as longs as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.