BROWNSBORO PARK PEDIATRICS

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THIS FORM MUST BE FILLED OUT AND SIGNED BY THE PATIENT OTHERWISE IT'S NOT LEGAL

Name_____ DOB: _____

Home Address: _____

City _____ State _____ Zip _____

Cell Number: _____ S.S # _____

Patient Email address: _____

Emergency Contact Name, Number and Relationship: _____

Do you have an advanced directive? _____ Yes _____No

An advance healthcare **directive**, also known as living will, personal **directive**, advance **directive**, **medical directive** or advance decision, is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

I understand it is my responsibility to verify my insurance benefits and coverage before each visit. _____

I understand that now that I am over the age of 18 years, I am now responsible for my own copay, co-insurance, deductible, and any other charge not covered by my insurance policy. _____

INSURANCE INFORMATION

Primary Insurance_____ Employer_____

Subscriber Name_____ Subscriber Date of Birth_____

Member/Subscriber ID#_____ Group #_____

I authorize the staff to mail information regarding my medical matters to the following address:

I give permission for Brownsboro Park Pediatrics to speak to the following people regarding my medical matters:

_____ Relationship _____

_____ Relationship_____

Signature_____ Date: _____