MOUNTAINLAND
PEDIATRICS

All information must be completed

Mother/Guardian of Child _____SSN#_____

Address _____Date of Birth_____

Phones: Home_____ Work _____ Cell_____

Employer _____ Position_____ Length of time at job_____

Father/Guardian of Child_____SSN#_____

Address _____Date of Birth_____

Phones: Home_____ Work _____ Cell_____

Employer _____ Position_____ Length of time at job_____

Financially Responsible Party_____

Name of Emergency Contact _____ Phone _____

Former Pediatrician _____

Primary Language Spoken by child(ren)_____Primary Language Spoken by Parents_____

Child(ren) live with _____

Full Legal Names of ALL Children that will be patients (oldest to youngest)

First Middle Last M/F Date of Birth

- _____
- _____
- _____
- _____
- _____

Patient has State of Colorado Medicaid: (circle) YES or NO PRIMARY OR SECONDARY

Insurance Coverage Information

Insurance card must be presented at each visit

Primary Insurance:

Effective Date: _____ Today's Date: _____

Insurance Company: _____ Co-pay: _____

Policy Holder (Guarantor): _____

Guarantor's Social Security #: _____Date of Birth: _____

Insurance Policy/ID #: _____

Insurance Group #: _____

Employer: _____

Employer Phone #: _____

Insurance Address: _____

Insurance Phone Number: _____

Names of Children on this policy:

- _____
- _____
- _____
- _____

Secondary Insurance:

Insurance Company: _____ Co-pay: _____

Policy Holder: _____

Guarantor's Social Security #: _____Date of Birth: _____

Insurance Policy/ID #: _____ Insurance Group: _____

Employer: _____Employer Phone #: _____

Insurance Address: _____

Insurance Phone Number: _____

Names of Children on this policy: _____

The above information is current and correct. I understand that I am financially responsible for all charges incurred whether or not paid by insurance.

Signature: _____ Date: _____