WELCOME TO OUR PRACTICE
Reddy Pediatrics
NEW PATIENT INTAKE FORM

Patient's Last Name:	First Name:		MI:
Previous Name (if applicable):			
Social Security Number:	Date of Birth:	Age:	Gender:
Race:	Ethnicity:	Language:	
Pharmacy of Choice (Specify Location):			

Please fill out child's personal information completely.

Guardian/Responsible Party:

Last Name:	First Name:		MI:
Relationship:	Social Security Number:		Date of Birth:
Physical Address:			
Apartment/Unit #:	City:	State:	Zip Code:
Mailing Address (if different):			
Apartment/Unit #:	City:	State:	Zip Code:
Home Phone:	Cell Phone:		Work Phone:
Email Address:			Work Place:

Other Parent:

Last Name:	First Name:		MI:
Relationship:	Social Security Number:		Date of Birth:
Physical Address:			

WELCOME TO OUR PRACTICE
Reddy Pediatrics
NEW PATIENT INTAKE FORM

Apartment/Unit #:	City:	State:	Zip Code:
Mailing Address (if different):			
Apartment/Unit #:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:		Work Place:	

In the event we cannot reach either parent, please give us an emergency contact:

Name:	Relationship:
Address:	
Contact Number:	

WELCOME TO OUR PRACTICE
Reddy Pediatrics
NEW PATIENT INTAKE FORM

Child's Insurance Information:
For verification of all insurance benefits, we require a copy of your insurance card and photo ID at registration.

Primary Insurance Name:		
Address:		
Phone Number:		
Member ID Number:	Group Number:	
Policy Holder's Name:	Date of Birth:	Phone Number:
Policy Holder's Address:		
Secondary Insurance Name:		
Address:		
Phone Number:		
Member ID Number:	Group Number:	
Policy Holder's Name:	Date of Birth:	Phone Number:
Policy Holder's Address:		

WELCOME TO OUR PRACTICE
Reddy Pediatrics
NEW PATIENT INTAKE FORM

Authorization and Assignment:
I authorize Reddy & Associates, LLC to release medical records to my employer or any insurance company with whom I have medical benefits for the purpose of filing medical claims. I also authorize any physician, hospital, or clinic to provide medical information required in the course of my examination or treatment. ***I give consent for Reddy & Associates, LLC physicians to obtain Rx history from external sources.***

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative.

Insurance is filed as a courtesy. It is the patient/guardian responsibility to ensure all bills are paid. All co-pays, deductibles, and co-insurance are due at the time of services.

Assignment of Benefits Payment:
I authorize my health insurance benefit plan to pay directly to Reddy & Associates, LLC. I understand that I am financially responsible to Reddy & Associates, LLC for any non-covered charges. If I am a self-pay patient, I understand that I am responsible for all charges in full at the time of service. ***I have read and understood the Financial Policy terms and conditions revised on 2/13/2015.***

Signature:	Relation to Patient:	Date:

HOW DID YOU HEAR ABOUT REDDY PEDIATRICS?

Web	Newspaper	Magazine	Radio	Billboard	TV	Word of Mouth

Revised 05/11/2016 (vkh)