High Mountain Healthcare, LLC

Pediatric Information Sheet – Annual Update

Today's Date:_____

Patient's Last Name_____First_____Middle Initial_____

Mailing Address_____ City/State/Zip_____

Hm. Phone (____)_____Wk Phone (____)_____ Cell Phone (____)_____

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

Race_____Ethnicity_____Preferred Language_____

Mother's Name_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (____)_____Wk Phone (____)_____ Cell Phone (____)_____

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____Marital Status: M S D W Employed by:_____

Father's Name_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (____)_____Wk Phone (____)_____ Cell Phone (____)_____

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____Marital Status: M S D W Employed by:_____

If not in parents care:

Guardian Name_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (____)_____Wk Phone (____)_____ Cell Phone (____)_____

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____Marital Status: M S D W Employed by:_____

EMERGENCY CONTACT (Someone who does not live with you):

Name_____ Relationship to patient_____

Hm Phone_____Wk Phone_____Cell Phone_____

Insurance Information
(Please provide a copy of your cards)

Primary Insurance Company Name_____

Secondary Insurance Company Name_____

Third Insurance Company Name_____

IF INSURANCE HOLDER IS DIFFERENT FROM PATIENT:

Name_____ Relation to patient_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (____)_____Wk Phone (____)_____ Cell Phone (____)_____

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____Marital Status: M S D W Employed by:_____

Employers Address_____City/State/ Zip_____

I certify that the above information is correct. I understand the office financial policies and procedures. I understand that High Mountain Healthcare reserves the right to add 10% collection fee and any additional attorney fees that may apply to my account if it is forwarded to a collection agency.

Signature of patient or guardian_____

Pediatric Medical Information and Treatment Release Form

Patient Name:_____ DOB:_____

Please list the names below that may bring your child/children to see a provider at High Mountain Healthcare, LLC for treatment in your absence. If you do not have a person listed and they bring child for an office visit, we will have to reschedule the appointment.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Information on my child may be released to:

Parent(s)_____

Other_____

___I authorize messages regarding my childs medical care to be left on any phone number that I have provided.

___I authorize the release of information including the diagnosis, records, claims information, and examination rendered to my child.

This release of information will remain in effect until terminated by me in writing.

By signing below I am confirming that I am the patient, legal guardian, or POA of the above named patient.

Printed Name and Signature: Date: