PEDIATRIC MEDICINE, PLC. 52 TIMBER LANE 802-658-2320
SOUTH BURLINGTON, VT 05403 www.pedimedvt.com

Primary contact person for automated reminder call & texts.

Parent name: ___________________________________ Date of birth: ________________________________
(or legal guardian)
Mailing address: _________________________________ Cell #: _______________________

____ Home #: ______________________

Employer: ______________________________________ Email: _______________________________________

Parent name: ___________________________________ Date of birth: ________________________________
(or legal guardian)
Mailing address: _________________________________ Cell #: _______________________

____ Home #: ______________________

Employer: ______________________________________ Email: _______________________________________

Emergency Contact
Name: ____ Phone: __________________________________

Relationship: _________________________________

Who holds primary insurance _____________________ Insurance company & ID #________________________

Who holds secondary insurance ___________________ Insurance company & ID #________________________

*Please provide insurance card(s) to the front desk.

If you have coverage with a company that we do not have a contract with, you are responsible for payment at the time of service. It will be your responsibility to submit your claim to that insurance company.

If you do not have insurance, you will be billed directly for payment of services. We accept check, cash and most credit cards. If you would like to set up a payment plan, please contact our billing office. If you are a custodial parent, by law you are ultimately responsible for payment of your child's medical bills, unless otherwise written. Our agreement to care for your child is made with you.

By signing below, I authorize that:

I have been offered a copy of Pediatric Medicine's HIPAA statement.

- Payment of medical benefits may be made to the physician or supplier for services rendered.
- That Pediatric Medicine may release any medical or other information necessary to process claims.

I also understand and agree that I am responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status.

Parent Signature____Date________________________

Please complete both sides.

Please include all children and list cell phone number of patients over 16 years of age.

First name ___________________________________ **Last name**_____________________________________

D.O.B: _____________ **Dr**: ________________ **Email**: _________________________ **Cell**: _____________

Sex assigned at birth: □Male □Female □ Decline to answer

Gender Identity: □Male □Female □Transgender (□ Male-to-Female or □ Female-to-Male)
□Genderqueer, neither exclusively male nor female □Decline to answer

Sexual Orientation: □Lesbian, gay or homosexual □Straight or heterosexual □Bisexual □ Do not know
□Choose not to disclose □ Something else

Race (√ all that apply): □American Indian or Alaskan Native □ Asian □Black or African American □Hispanic
□ Native Hawaiian or other Pacific Islander □White □Other Race: ______ □Decline to answer

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ Decline to answer

Primary language: □English □Other _________________

First name ___________________________________ **Last name** __________________________________

D.O.B: ______________ **Dr**: ________________ **Email**: ________________________ **Cell**: ____________
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Please complete both sides.