Beittel-Becker
PEDIATRIC ASSOCIATES

Patient Enrollment Form

LIST THE FULL NAME AND DATE OF BIRTH OF THE CHILDREN YOU ARE ENROLLING

The government is asking us to track Race & Ethnicity please circle all that apply.
If you choose you can leave blank and we will put "not provided/refused"

1. _____
LAST FIRST DOB
Race: American Indian Asian Hawaiian Black White
Ethnicity: Hispanic/Latino Non-Hispanic/Latino

2. _____
LAST FIRST DOB
Race: American Indian Asian Hawaiian Black White
Ethnicity: Hispanic/Latino Non-Hispanic/Latino

3. _____
LAST FIRST DOB
Race: American Indian Asian Hawaiian Black White
Ethnicity: Hispanic/Latino Non-Hispanic/Latino

4. _____
LAST FIRST DOB
Race: American Indian Asian Hawaiian Black White
Ethnicity: Hispanic/Latino Non-Hispanic/Latino

PARENT'S INFORMATION:

Child/Children Reside with ☐ Both Parents ☐ Mother ☐ Father ☐ Other:_____

Father's Name: _____ **Mother's Name:**_____

Address:_____ Address:_____

_____ZIP:_____ _____ZIP:_____

Phone: (H)_____(C)_____ Phone: (H)_____(C)_____

Primary Email:_____ Secondary Email:_____

Father's Date of Birth:_____ **Mother's Date of Birth**_____

Social Security #: _____ Social Security #: _____

Person to notify in case of emergency or if parents can't be reached (relative, friend, someone other than the parent)

_____
NAME Relationship Phone No.

INSURANCE INFORMATION

Please Note – We need all insurance information before your insurance can be effective with Beittel-Becker. Many insurance companies require S.S. # and DOB of parent to submit claims. Failure to provide accurate and timely information may result in you being responsible for the charges.

#1 **PRIMARY INSURANCE CO. NAME:**_____COPAY $:_____

Owner of Policy/Policy Holder: ☐ Father ☐ Mother ☐ Child ☐ Other:_____

ID Child #1_____ ID Child #2_____
ID Child #3_____ ID Child #4_____
Group #_____ Effective Date:_____

#2 SECONDARY INSURANCE CO. NAME:_____COPAY $:_____

Owner of Policy/Policy Holder: ☐ Father ☐ Mother ☐ Child ☐ Other:_____

ID Child #1_____ ID Child #2_____
ID Child #3_____ ID Child #4_____
Group #_____ Effective Date:_____

Authorization to Release Information – Assignment of Benefits- Receipt of Privacy Policies

I authorize release of medical information necessary to process medical claims on behalf of the above-named patient. I authorize Donna L Brosbe MD, Greta L Laube MD, David Brown DO, Joaquin J Garcia PA-C, & Brian A. Martin, PA-C to apply for benefits on behalf of the above named patient for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to Beittel-Becker Pediatric Associates. I permit a copy of this authorization to be used in place of original. I may revoke this authorization at any time in writing. I also have had an opportunity to review a copy of the Notice of Privacy Practices Dated 4/15/03. I note that I am financially responsible to make sure payment is made. I also attest that I have legal authority to make these authorizations & assignments for above- named patient.

Signature: _____

Date Signed: _____

For Office Use Only:
Received By:_____ Date:_____
Entered By: _____Date:_____
Make sure to enter data for all kids and parents