Canadian Valley Pediatrics

PATIENT INFORMATION

Patient Name : ☐ MALE ☐ FEMALE

Patient Date of Birth: _____ **E-MAIL:** _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

CELL: _____
CARRIER: _____
CELL: _____
CARRIER: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ **Cell:** _____
NAME RELATIONSHIP

GUARANTOR INFORMATION

Name: _____ **Occupation:** _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

CELL: _____
SSN: _____
DOB: _____

E-Mail: _____

INSURANCE INFORMATION

Primary Insurance: ..... **Effective:** .....

Carrier's Name: ..... **Date of birth:** .....

ID Number: ..... **Group Number:** .....

Seconadry Insurance: ..... **Effective:** .....

Carrier's Name: ..... **Date of birth:** .....

ID Number: ..... **Group Number:** .....

Please sign and date below.

Sign: _____ **Date:** _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES
Updated 2017

Child's Name: ..... **Date of Birth:** .....

I understand there will be a $25 charge for ALL missed appointments if a 24 hour is NOT given.

I understand that I may be charged $20 for any afterhour's calls.

I understand if any services or charges are not cover through insurance or if the office of Dr. Dina Bowen, MD. is unable to verify eligibility, I will be held responsible for all charges incurred for services rendered.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered and if I am unable to pay for services rendered in a timely manner all claims will be turned over to collections.

I authorize direct payment to be made to the office of Dr. Dina Bowen, M.D. (the Practice) for any and all medical or surgical services rendered.

I hereby authorize the office of Dr. Dina Bowen to release any information concerning my health care, advice, treatment or services provided. This information is to be used in administering medical claims and/or discussing treatment options with insurers and/or other medical providers outside of the Practice when necessary so that these providers may treat my child; seek payment for treatment and for the purpose of their health care operations

The Practice is authorized to disclose my child's medical information and remind me of appointments on my home answering machine, voicemail, text or email.

I have reviewed the Notice of Privacy Practice. I understand I may receive a printed copy of this information upon verbal or written request now or in the future. I authorize the Practice to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g. quality assurance).

The following family members/ friends have my permission to accompany my child to his/her medical appointment: (please print only people over the age of 18 and their relationship to the patient. For example: Tom Jones, grandfather)

_____

_____

_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status, medication changes, address changes or insurance changes, I shall inform the doctor and staff at the next appointment without fail.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Sign: _____ **Date:** _____