NEW PATIENT INFORMATION SHEET
PLEASE COMPLETE ALL SECTIONS AND RETURN TO RECEPTIONIST

PATIENT_____ ADDRESS_____
(First) (Last) (Middle Initial)

DATE OF BIRTH_____ CITY_____

PHONE (_____)_____ STATE/ZIP_____

PT'S SOCIAL SECURITY NUMBER_____PT GENDER: MALE / FEMALE

PARENT/LEGAL GUARDIAN (Mom)_____(Dad)_____

PARENT/LEGAL GUARDIAN'S EMPLOYER (Mom)_____(Dad)_____

PRIM INS_____ SECOND INS_____

SUBSCRIBER NAME_____ SUBSCRIBER NAME_____

SUBSCRIBER'S DATE OF BIRTH_____ SUBSCRIBER'S DATE OF BIRTH_____

SUBSCRIBER'S SOC SEC #_____ SUBSCRIBER'S SOC SEC #_____

RLNSHIP TO SUBSCRIBER_____ RLNSHIP TO SUBSCRIBER_____

GROUP #_____ GROUP #_____

CONTRACT #_____ CONTRACT #_____

PERSON TO CONTACT IN CASE OF EMERGENCY/PHONE_____

ALTERNATE EMERGENCY CONTACT/PHONE_____
(Not living at same address as first contact)

DRUG ALLERGIES_____

Lossio Pediatrics, PLLC participates with a variety of health care plans including Medicaid, Molina Medicaid, most Michigan BCBS Plans, Blue Care Network, ConnectCare, Aetna, Cofinity, Health Care Alliance Pool, The Chandler Group, McLaren Commercial and Medicaid; MidMichigan Health Plan, CIGNA, Priority Health, HealthPlus, Midland Health Plan, Central Health Plan, Physicians Health Plan, and TriCare/Tricare Prime. Participation means that we hve a contract with these insurance companies and must accept their "allowable" fee as payment in full. Deductibles, co-pays and non-covered services are not included. If we do not participate with your insurance carrier, you may still have a balance after your insurance company has paid. If your insurance plan is not listed, please check with your insurance carrier and/or your employer to ask about participation prior to receiving any services. Participation is subject to change. As a courtesy to our patients, Lossio Pediatrics, PLLC submits claims to all carriers, regardless of our participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day service is rendered, or for paying in full if we do not participate with your health care plan.

I understand that my insurance policy is a contract between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time services are rendered. I agree to be financially responsible for all costs incurred by my dependent child in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by this office, whether conducted in this office or elsewhere, which are not otherwise paid by my insurance.

I hereby authorize Lossio Pediatrics, PLLC or its designees to bill and release to my insurance company and/or third party payor(s) and/or external review agency(s) such information contained in my child's patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history or illness or diagnostic and therapeutic information.

Signature:_____ Date:_____
(LEGAL PARENT OR GUARDIAN)