Welcome to Y2K

Patient's Name _____ Sex _____ DOB _____ SS# _____

Address _____

City _____ State _____ Zip _____ Telephone _____

Emergency Contact (name and number) _____

Mother's Name _____ DOB _____ SS# _____

Address _____

Cell# _____ City _____ State _____ Zip _____

Employer _____ Work# _____ Ext _____

Father's Name _____ DOB _____ SS# _____

Address _____

Cell# _____ City _____ State _____ Zip _____

Employer _____ Work# _____ Ext _____

With whom does the child live? _____

Name, address and telephone number of other persons authorized to bring child for treatment?

_____

_____

_____

Insurance Information

Primary Insurance _____ ID# _____ Group# _____

Insured Name _____ DOB _____ SS# _____

Secondary Insurance _____ ID# _____ Group# _____

Insured Name _____ DOB _____ SS# _____

I _____ , being legal parent/guardian of _____ hereby authorize Y2K Pediatrics Inc. to administer medical treatment to my child. I also authorize payment of medical benefits on my insurance policy to be made directly to Y2K Pediatrics, Inc. and Christine George-Wray M.D. for services rendered. I understand that I am financially responsible for charges not paid by my insurance carrier. I further authorize the release of any medical information required by my insurance carrier or plan administrator. I understand that Dr. Wray does not carry medical malpractice insurance.

Parent or Guardian Signature _____ Date _____

Y2K Pediatrics, Inc.

Authorization for Release of Information

Patient Name _____

I authorize Y2K Pediatrics Inc. to release all medical information including, but not limited to, information on psychiatric conditions, alcohol and drug abuse, and HIV or other communicable diseases requested by my health insurance carrier, Medicare/Medicaid or any other third-party payers.

I authorize Y2K Pediatrics, Inc. to release all medical information to other physicians, health-care providers or any other medical facility as it relates to my medical treatment and care.

I authorize Y2K Pediatrics, Inc. to contact my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Y2K Pediatrics, Inc.

I agree that these provisions will remain in effect until I provide written revocation to Y2K Pediatrics Inc.

I understand that Y2K Pediatrics, Inc. may at times need to contact me about medical, financial, or other business. I will therefore inform the office of any changes in my contact information in a timely manner.

Signature of Patient /Legal Guardian _____ Date _____