Cottonwood Pediatrics
A Division of Wasatch Pediatrics, INC.

Preferred Doctor: ___________________________Preferred Pharmacy and Phone #:____

Patients Legal Name: ____D.O.B.________________ Sex: M F
Physical Address of Patient: ____City: ________________________Zip:__________________
Whom does child live with? ____
Who is authorized to seek medical care for your child? ____
Who is authorized to receive financial info on this account? ____

Fathers Information: Email: ____

First Name: _______________________ Last Name: __________________________________D.O.B.______________________________
Phone No.________________________ Cell Phone: ________________________________ SS#_______________________________
Address: ____ Zip: _____________ City: ____________________ State: _______________
Employer__________________________ Phone No._______________ Address: ____
Drivers License number: _______________________________ State: ____

Mothers Information: Email: ____

First Name: ________________________ Last Name: ________________________________ D.O.B.____________________________
Phone No._________________________ Cell Phone: ________________________________ SS#______________________________
Address: ____ Zip: _____________ City: ____________________ State: _______________
Employer___________________________ Phone No.____________________ Address: ____
Drivers License number: ______________________________ State: ____

Insurance Information:

Primary Insurance Co.:_________________________________ Policy Holder's Name **and** D.O.B:_______________________________
Policy No. ________________________________ Group No. ____________________ Effective Date: ____________________________
Address: ____ Zip: _____________ City: _________________ State: _________________
Phone No. __________________________ Fax No. ____

PLEASE ADVISE IF THERE IS A SECONDARY INSURANCE WE ARE TO BILL.

Nearest Relative: ____ Phone #: ____
Emergency Contact & Phone #____ Relationship to child: ________________________

List below any additional Children's names and dates of birth:

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I understand payment is due at the time of service. Because I am the one seeking care for this patient, regardless of insurance coverage or other parties' responsibility, I am ultimately the person to be responsible for this account. I understand that a service fee will be added if co-pays are not made at the time of service. I agree to pay for each service charged on my account within 30 days. Late charges may be added on any balance older than 60 days at 1.5% per month (18%APR). Wasatch Pediatrics will bill the above insurance for services. I authorize any insurance payments to be sent directly to Wasatch Pediatrics, Inc. Insurance payments not received within 60 days of submitting claims are subject to terms of this agreement.
If collection is necessary, I agree to pay an attorney, collection agency, and/or court costs equal to one-third of the amount owing. If requested, records may be released to third party payors for the purpose of payment of insurance claims. I understand that I will be required to present my insurance card at each visit and it is my responsibility to understand my own insurance. I may make payment to Wasatch Pediatrics by cash, check, credit, or debit card. I give my permission for Wasatch Pediatrics to disclose medical information as needed for the purpose of treating this patient.

____ __________________________________
SIGNATURE DATE: