# Please Complete The Entire Form

**Ramsey Pediatric Center**
**Yearly Patient Update**

**Patient's Information**

Patient Name: _____ ☐ Male ☐ Female Date of Birth _____
First Middle Last

Patient Name: _____ ☐ Male ☐ Female Date of Birth _____
First Middle Last

Patient Name: _____ ☐ Male ☐ Female Date of Birth _____
First Middle Last

Patient Name: _____ ☐ Male ☐ Female Date of Birth _____
First Middle Last

Patient Name: _____ ☐ Male ☐ Female Date of Birth _____
First Middle Last

**PatientHome Address:** _____
Street Number City State Zip

Day Phone # _____ Cell # _____

Pharmacy Name and Exact Location/phone number _____

**Primary Insurance Policy Holder Information**

Name: _____ Date of Birth _____
First Middle Last

**Insured Home Address:** _____
Street Number City State Zip

Preferred Phone # _____ Relationship to patient: _____ ☐ Male ☐ Female

SS # of Policy Holder: _____ Employer: _____

Name of Insurance: _____ ID # _____ Group# _____

**Parent/Guardian Information**

Mother's Name: _____ Date of Birth _____
First Middle Last

Preferred Phone# _____ Employer: _____

Father's Name _____ Date of Birth _____
First Middle Last

Preferred Phone# _____ Employer: _____

**Authorization to Contact**

Please mark the preferred way you would like to be contacted for appointment reminders

☐ Phone ☐ Voice and Text _____ ☐ Voice ONLY _____

☐ Email address _____

Signature: _____ Relationship to Patient: _____ Date:_____

**Authorization to Treat**

I give the following individuals permission to bring my child to your office and make necessary medical decisions regarding treatment:

_____ _____ _____

Signature: _____ Relationship to Patient: _____ Date:_____

**Financial Statement and Authorization for Treatment**

**Minors must be accompanied by an adult. The person bringing the patient to the appointment is responsible for all payments due at time of service.**

I understand that I am financially responsible for all services not covered by my insurance company. I also understand that it is the parents/guardians responsibility to provide this office with the correct insurance information. I understand that in not doing so I will be responsible for services that are billed after the filing deadline.
I authorize the release of any and all medical and personal information necessary to process claims.
I authorize Karla S. Ramsey, MD, PA. to treat the above named patient. I certify that all the above information is current and correct and I agree to notify office of any changes.

Signature: _____ Relationship to Patient: _____ Date:_____

**FOR OFFICE USE ONLY**

Patient Info updated ☐ Health Insurance updated ☐ Email entered if provided ☐
All siblings updated ☐ Health Insurance for siblings ☐
Pharmacy updated ☐ Data Entered by _____ Date _____
Pharmacy siblings ☐ Scanned by _____ Date _____