Please Complete The Entire Form

Ramsey Pediatric Center
Yearly Patient Update
Patient's Information

2021

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

ECW must be updated before this form can be scanned

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 _____