



*Update of Contact Information & Insurance Form*

**Patient Information**

Patient's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Email address: \_\_\_\_\_

Other children in the family who require an update in contact information:

\_\_\_\_\_

**Primary Insurance (Person who holds insurance)**

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group Name or # \_\_\_\_\_  
Policy Effective Date \_\_\_\_\_ Copay Amount: \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Driver License Number: \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

**Secondary Insurance (If child has multiple insurance coverage)**

Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group Name or # \_\_\_\_\_  
Policy Effective Date \_\_\_\_\_ Copay Amount: \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
Cell Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

Other children in the family who require update in insurance information:

\_\_\_\_\_

**Insurance Assignment & Release of Information**

- I authorize the release of my child's any medical information necessary to process insurance claims.
- I authorize the release of payment of medical benefits to my child's provider.
- I understand that I am financially responsible for any deductible & coinsurance fees, and charges for non-covered services. Unless I am a member of an insurance organization that Ivy Pediatrics/PedEmerge is a contracted provider, all charges are due at the time that services are rendered.
- I authorize Ivy Pediatrics/PedEmerge to call me on my home/cell/work numbers for collection purposes.

\_\_\_\_\_  
Guarantor's Signature

\_\_\_\_\_  
Date