Warner and Jansen Pediatric
Patient Information Form

Patient Information:

Patient's Name: First___________________________ MI_____ Last ________________________________

DOB:_____________________ SEX: [ ]M [ ]F SSN#____

Primary Guardian/Financially Responsible:

Name:________________________________ Phone #_________________________ [ ]Home [ ] Cell

Address: _____________________________________ City:___________________ State:____ ZIP:_______

Employer:____Work Phone: (___)______________________

Date of Birth:____________________________ Social Security #:___________________________________

Other Parent/Guardian Contact Information:

Name:________________________________ Phone #_________________________ [ ]Home [ ] Cell

Address: _____________________________________ City:___________________ State:____ ZIP:_______

Employer:____Work Phone: (___)______________________

Date of Birth:____________________________ Social Security #:___________________________________

Siblings Name(s):

____ DOB:_____________________________

____ DOB:_____________________________

____ DOB:_____________________________

Other Important Contacts:
Name:________________________________ Phone: _____________________ Relationship: ___________

Name:________________________________ Phone: _____________________ Relationship: ___________

*Insurance Coverage is a contract between you and your insurance company. It is your responsibility to know what your plan does and does not cover.
*Our office will file insurance claims for you, but you will be responsible for amounts not paid by your insurance within 90 days.
*I understand that co-payments are due at the time of service.
*I consent to be contacted by mail and by telephone (including cell phones) regarding any matter related to my account with Dr. Warner and Dr. Jansen Pediatrics, PLLC.
*I authorize the release of any medical information necessary to process this claim. I also authorize my insurance company to make payments directly to Warner and Jansen Pediatrics, PLLC.

*As the parent/guardian of the above child I hereby authorize and consent to the examination and/or treatments of my child during office and facility visits by physicians and clinical staff of Dr. Warner and Jansen's Pediatrics.

Signature:____Date:______________________________