

# Comfort Care Pediatrics, Inc.

4546 South 815 West, Suite 204

Taylorsville, UT 84123

## PATIENT INFORMATION

Children's Name(s) / Birthdate(s)

1. _____	DOB: _____	5. _____	DOB: _____
2. _____	DOB: _____	6. _____	DOB: _____
3. _____	DOB: _____	7. _____	DOB: _____
4. _____	DOB: _____	8. _____	DOB: _____

\_\_\_\_\_ ← To whom bill is sent (check one) → \_\_\_\_\_

**Father** \_\_\_\_\_

Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Work phone \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group No. \_\_\_\_\_ Contract \_\_\_\_\_

Parents (circle one): Unmarried Living together

Whom may we thank for referring you to our office \_\_\_\_\_

Nearest relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

**Note:** In case of emergency, we must have a phone number of a friend, neighbor, or relative who can reach you or a member of your family. If you have a post office box number, we must have the address of a residence where you can be reached.

Phone \_\_\_\_\_ Name of resident at that number \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip

I understand and agree that if I do not cancel an appointment at least 24 hours in advance, I will be charged a \$25 fee. I also understand that if I do not pay the co-payment at the time of service, I will be charged an additional \$10 billing fee.

I understand and agree that my account is due and payable upon receipt of the bill. I understand and agree that a finance charge of 1½% per month (18% per year) may be charged on my account if it is 30 days past due. If no payment is made on my account within 3 months of service rendered, the account may be submitted to a certified collection agency. In this event, I agree to pay a 30% collection fee and all court costs and attorney fees involved in the transaction.

I authorize Comfort Care Pediatrics, Inc. to furnish my designated insurance carrier with all information concerning my child's health care. I also authorize benefits to be made directly to Comfort Care Pediatrics, Inc. I understand I am responsible financially to Comfort Care Pediatrics, Inc. for charges not covered by my insurance carrier.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date