Comfort Care PEDIATRICS

495 East 4500 South, Suite 200
Salt Lake City, UT 84107

Family Information (*For All Patients) – Please Use Full Legal Name*

Father's/Parent/Legal Guardian's Name:_____
Lives with patient? YES / NO. **List mailing address:**_____
City:_____ State:_____ Zip:_____
Date of Birth:____/____/_____ Social Security #:_____-_____-_____
Home Phone No:_____-_____-_____ Cell Phone No:_____-_____-_____ Email:_____
Employer:_____ Occupation:_____ Work #:_____-_____-_____

Mother's/Parent/Legal Guardian's Name:_____
Lives with patient? YES / NO. **List mailing address:**_____
City:_____ State:_____ Zip:_____
Date of Birth:____/____/_____ Social Security #:_____-_____-_____
Home Phone No:_____-_____-_____ Cell Phone No:_____-_____-_____ Email:_____
Employer:_____ Occupation:_____ Work #:_____-_____-_____

If parents are divorced/separated/not married – please fill out this section
Who has legal custody?_____ Is there court documentation? YES / NO
Who lives in the household?_____

Insurance

Primary Policyholder's Name:_____ Date of Birth:____/____/_____
Insurance Carrier:_____
ID #:_____ Group #:_____
Secondary Policyholder's Name:_____ Date of Birth:____/____/_____
Insurance Carrier:_____
ID #:_____ Group #:_____

Primary Care Physician: (please circle one)

Rita Fox, MD / Cynthia Carmack, MD / Glen Frick, MD

Emergency Contact (This person should live in the same state, but not in the same household)

Name:_____ Phone:_____-_____-_____ Relationship:_____
Name:_____ Phone:_____-_____-_____ Relationship:_____

Continued on Reverse

Children Information *(Please Use Full Legal Name)*

Child 1: Last Name:_____ First Name:_____M.I.__ DOB:____/____/____

Male/Female Ethnicity: Hispanic/Non-hispanic/Unknown Race:American Indian or Alaskan Native/Asian/Black or African American Hawaiian Native or Pacific Islander/White/Other

Child 2: : Last Name:_____ First Name:_____M.I.__ DOB:____/____/____

Male/Female Ethnicity: Hispanic/Non-hispanic/Unknown Race:American Indian or Alaskan Native/Asian/Black or African American Hawaiian Native or Pacific Islander/White/Other

Child 3: Last Name:_____ First Name:_____M.I.__ DOB:____/____/____

Male/Female Ethnicity: Hispanic/Non-hispanic/Unknown Race:American Indian or Alaskan Native/Asian/Black or African American Hawaiian Native or Pacific Islander/White/Other

Child 4: Last Name:_____ First Name:_____M.I.__ DOB:____/____/____

Male/Female Ethnicity: Hispanic/Non-hispanic/Unknown Race:American Indian or Alaskan Native/Asian/Black or African American Hawaiian Native or Pacific Islander/White/Other

Child 5: Last Name:_____ First Name:_____M.I.__ DOB:____/____/____

Male/Female Ethnicity: Hispanic/Non-hispanic/Unknown Race:American Indian or Alaskan Native/Asian/Black or African American Hawaiian Native or Pacific Islander/White/Other

Child 6: Last Name:_____ First Name:_____M.I.__ DOB:____/____/____

Male/Female Ethnicity: Hispanic/Non-hispanic/Unknown Race:American Indian or Alaskan Native/Asian/Black or African American Hawaiian Native or Pacific Islander/White/Other

How did you hear about us and who should we thank for the referral?_____

Payment in full is due within 60 days from the date of service. If payment in full is not made as required, then in addition to all other amounts that may be due I agree to pay a collection fee of up to 40% of the principal amount as provided by §12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection(weather incurred by Comfort Care Pediatrics or its assigns) including but not limited to court cost, reasonable attorney fees, and interest (both pre-and post-judgement). Any interest due hereunder shall be calculated at a rate equal to 18% per annum and may, as determined by Comfort Care Pediatrics or its assigns: (a) accrue on some or all amounts due and (b) compound as frequently as daily—meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period. The terms of this paragraph shall apply to all amounts(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Comfort Care Pediatrics or anyone acting on its behalf. I understand and agree that such calls may be initiated by Comfort Care Pediatrics or any of its affiliates, agents, contractors or assigns, including but not limited to companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages- some or all of which may result in data charges. I also consent to receiving e-mails at any email address provided by me or anyone associated with me or acting on my behalf.

(1)Legal Guardian Signature:_____ **Date**:____/____/_____

Printed Name:_____

(2)Legal Guardian Signature:_____ **Date**:____/____/_____

Printed Name:_____

Revised: August 13, 2019