PATIENT INFORMATION

Lynn Keefe, MD
pediatrics

2600 Partin Drive N Bldg. 300, Ste. 320
Niceville, FL 32578
850-279-6260

PATIENT'S FULL NAME:	
NICKNAME	
BIRTHDAY / /	SEX M F

PRIMARY CUSTODIAL PARENT/GUARDIAN

Name: _____ _____ _____ Relation To Patient: _____
First Middle Last

Address: _____
Street City State Zip

Birthday: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____
Street City State Zip

Name of Relative Contact: _____ _____ _____ Relation To You: _____
First Middle Last

Address: _____ Phone: _____
Street City State Zip

Name of Friend/Emergency Contact: _____

Address: _____ Phone: _____
Street City State Zip

SPOUSE OF PRIMARY CUSTODIAL PARENT/GUARDIAN

Name: _____ _____ _____ Relation To Patient: _____
First Middle Last

Birthday: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____
Street City State Zip

INSURANCE

Insurance Company: _____ Plan Name: _____ Insured's ID#: _____

Insured Member's Name: _____ Relation to Patient: _____

If Employer Group Insurance, Name Employer: _____ Group #: _____

For Insurance Plans of **Non-Participation** Provider Status:

I understand that ***Lynn Keefe MD, Pediatrics*** *(IS NOT) a participating provider of my insurance plan and that I am responsible for payment of professional services rendered at time of service. I authorize release of medical information required to process insurance claims to my plan on my behalf.*

_____ _____
Signature of parent/guardian Date

For Insurance Plans of **Participation** Provider Status:

I understand that ***Lynn Keefe MD, Pediatrics*** *(IS) a participating provider of my insurance plan and that I am responsible for payment of applicable deductible, coinsurance, co-pay, and any "non covered" services pursuant to my plan contract.*
I authorize payment of benefits to ***Lynn Keefe MD, Pediatrics*** *for professional services rendered and authorize release of medical information required to process insurance claims.*

_____ _____
Signature of parent/guardian Date