CHANGE OF RESPONSIBLE PERSON & INSURANCE

All information must be completed

First **Middle** **Last** **M/F** **Date of Birth** ____________________

Race: ❑ Native American/Alaskan Native ❑ Asian ❑ Black/African American ❑ Hispanic ❑ White/Caucasian ❑ Other ❑ Declined

Mother/Guardian of Child/Patient ____________________ **SSN#** ____________

Address ____________________ **City** ____________ **Zip** ________ **Date of Birth** ________

Phones: Home ____________ **Work** ____________ **Cell** ____________

Employer ____________________ **Position** ____________________

Father/Guardian of Child ____________________ **SSN#** ____________

Address ____________________ **City** ____________ **Zip** ________ **Date of Birth** ________

Phones: Home ____________ **Work** ____________ **Cell** ____________

Employer ____________________ **Position** ____________________

Financially Responsible Party ____________________ **Email** ____________

Name of Emergency Contact ____________________

Relationship to Patient ____________________ **Emergency Contact Phone** ____________

Current Provider ____________________

Primary Language Spoken by child(ren) ____________ **Primary Language Spoken by Parents** ____________

Child(ren) live with ____________________

Preferred Pharmacy ____________________ **Address** ____________________

Patient has State of Colorado Medicaid: (circle) **YES or NO** **PRIMARY OR SECONDARY**

Insurance Coverage Information

Insurance card must be presented at each visit

Primary Insurance:

Effective Date: ______________________ **Today's Date:** ______________

Insurance Company: ______________________ **Co-pay:** ______________

Policy Holder (Guarantor): ______________________

Guarantor's Social Security #: ______________________ **Date of Birth:** ______________

Insurance Policy/ID #: ______________________ **Insurance Group #:** ______________

Employer: ______________________ **Employer Phone #:** ______________

Insurance Address: ______________________ **Insurance Phone Number:** ______________

Names of Children on this policy:

First	Middle	Last	M/F	Date of Birth

Secondary Insurance:

Insurance Company: ______________________ **Co-pay:** ______________

Policy Holder (Guarantor): ______________________

Guarantor's Social Security #: ______________________ **Date of Birth:** ______________

Insurance Policy/ID #: ______________________ **Insurance Group #:** ______________

Employer: ______________________ **Employer Phone #:** ______________

Insurance Address: ______________________ **Insurance Phone Number:** ______________

Names of Children on this policy: ______________________

The above information is current and correct. I understand that I am financially responsible for all charges incurred whether or not paid by insurance.

______________________ ______________

Signature **Date**

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