DEVELOPMENTAL PEDIATRICS
2210 Lelaray
Colorado Springs
CO 80909

New Patient Information

Date:_____

Patient Information:

Patient Name:_____ **Date of Birth:**_____ ☐**Male** ☐**Female**

Address:_____ **City, State, Zip:**_____

Physician:_____ Physician's phone #:_____

Diagnosis of Patient:_____

Does your child have an Individualized Education Plan? ☐Yes☐No School:_____ Grade:_____

Parent Information:

Mom's Name:_____ Mom's Cell Phone:_____

Mom's Work Place:_____ Mom's Work Phone:_____

Mom's Email:_____

Dad's Name:_____ Dad's Cell Phone:_____

Dad's Work Place:_____ Dad's Work Phone:_____

Dad's Email:_____

Primary Insurance Information:

Copays /Co-insurances are due at time service is rendered!

Insurance Company: (Tricare, Aetna, Cigna, etc)_____ Plan Name: PPO, HMO, POS, _____

Policy#:_____ Group #:_____ Phone #:_____

Policy Holder Date of Birth:_____ Policy Holder Name:_____

Relationship to Patient:_____ Policy Holder SS#:_____

Policy Holder Address:_____

Policy Holder Employer/Address/phone #:_____

Secondary Insurance:

(i.e.Medicaid, Aetna, Tricare,Cigna etc)

Policy Holder Name:_____ Medicaid#:_____

Insurance Company: _____ Plan Name: PPO, HMO, POS, _____

Policy#: _____ Group #:_____ Phone #:_____

TriCare Information: (Co-pay for retired E-4=$6.00 E-5 and above $12.00, Due at time of service)

Tricare Plan: (Prime, Standard) Rank of Sponsor: (E-1, E-2, O-1, and O-2) Sponsor's Status: Active, Retired, Deceased