Richard D. Green MD, FAAP
940 E. Third St. #102
Casper, WY 82601
307-577-4280

Today's Date__________________

Obstetrician (If Applicable) ______________________________________ Due Date__________________

Children's Names

(Circle One)

__________________________________ Birth Date___/___/___ F or M Drug Allergies______________
Last First MI

__________________________________ Birth Date___/___/___ F or M Drug Allergies______________
Last First MI

__________________________________ Birth Date___/___/___ F or M Drug Allergies______________
Last First MI

__________________________________ Birth Date___/___/___ F or M Drug Allergies______________
Last First MI

Other Casper doctors your children have seen? ____

Are there any areas of "special" concern? If so, please describe the concern and which child it concerns.

____

Are your child's immunizations "up to date"? __________ Can you provide a current copy? __________

NOTE: All immunizations are automatically posted on the Wyoming State Immunization Registry online.

Responsible Party (Parent / Guardian)

Father's Name: ____ Birth Date _____/_____/_____
Last First MI

SS#_________________ Employer ____________________________ Work # _____________________

Mother's Name: ____ Birth Date _____/_____/_____
Last First MI

SS#_________________ Employer ____________________________ Work # _____________________

Email Address: ____

Do we have permission to email information to you? YES or NO Please Initial: ________________

Physical Address: ____ Dad's Home # _______________

Mailing Address: ____ Mom's Home # ______________
(P.O. Box If Applicable)

City: ___________________________ State: ______ Zip Code: ____________ Cell # __________________

Length of Time at Present Address ________________________ Referred By: _______________________

Emergency Contact: ____________________________________ Phone # __________________________
(Not living in your home)

Insurance Information

Do you have **Equality Care (Medicaid)** Yes ____ No ____, OR **Kidcare**? Yes ____ No ____

Name of Child: 1) ______________________________________ ID#__________________________

2) ______________________________________ ID#_________________________

3) ______________________________________ ID#_________________________

Primary Insurance?

Insurance Company____

Insured's Name __________________________________ Insured's Date of Birth _____/_____/_____

Insured's ID# ____________________________________ Group # _____________________________

NOTE: We submit claims to BlueCross/Blue Shield, United Health Care (UHC), WINhealth, Cigna, and CNIC/WISE Network only. We are also in-network for Aetna, Meritain, and First Choice of the Midwest. For other insurance coverage, we request payment on the day of service and will provide an invoice for you to submit to your insurance. Benefits should then be sent directly to you. If for any reason your insurance sends us payment, we will promptly reimburse you.

***__Please bring a current insurance card to your first visit and any time your insurance changes.__**

Please initial to verify you have read the above statement: __________

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PLEASE READ THE FOLLOWING:

As a courtesy to this office and other patients, I understand it is my responsibility to call at least 24 hours in advance to cancel an appointment.

I hereby consent to the treatment of my child/children by Dr. Green and his staff, and have been offered a copy of the HIPAA Notice of Privacy Practices to review.

I agree that payment will be due to Richard D. Green MD, FAAP on the day of service for all "primary insurance" coverage or from patients who have no insurance coverage, unless prior agreement is established.

I understand it is my responsibility to notify this office and obtain the necessary form in order to allow the release of medical information. Forms are available upon request.

I give this office permission to call my home or designated location and leave a message on voicemail or speak in person regarding any information that assist this practice in carrying out TPO (Treatment, Payment, and Healthcare Operations) such as, but not limited to, appointment reminders, insurance and/or billing, and any clinical care information.

I hereby acknowledge that I have read and received a copy of this agreement available at my request.

*** ____ *** ______________________________

Signature of patient, or parent/legal guardian of a minor — Date of Signature

Witness ____ Date ____________________________