Drs. Bedingfield and Roswell, SC

Responsible Party's Name (**Parent/Guardian to be billed**):

Date:

List **ALL** children:

Last:	First	Date of Birth:

Primary Phone #:

Secondary Phone #:

May we leave medical information on Voicemail? Circle one: YES NO

May we leave medical information with another person? YES NO If YES, who?

Guardian's Last Name First Middle

Relationship to Patient:

Date of Birth: ____/____/________

Sex:

Ethnicity:
☐Not Hispanic
☐Hispanic/Latino

Preferred Language:

Race:
☐American Indian ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Pacific Islander ☐Other

Street Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Email: Occupation:

Guardian's Last Name First Middle

Relationship to Patient:

Date of Birth: ____/____/________

Sex:

Ethnicity:
☐Not Hispanic
☐Hispanic/Latino

Preferred Language:

Race:
☐American Indian ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Pacific Islander ☐Other

Street Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Email: Occupation:

Signature of Parent or Legal Guardian

Print Name of Parent or Legal Guardian

___/___/_____
Date

Updated Dec. 2020

Drs. Bedingfield and Roswell, SC

Text Appointment Reminders

To authorize us to opt you into our Text Appointment Reminders, provide your cell # and signature below:

Cell Phone:	______________________________ Signature

Insurance Information

Primary Insurance:	Subscriber Name:
Secondary Insurance:	Subscriber Name:

Private Health Information Release Authorization

I, the undersigned, certify that I have insurance coverage with the above listed insurance company (companies) and assign directly to Dr. D. Rosewell, Dr. Silver, Dr. Nourbash, Dr. K. Rosewell, and Dr. Din all insurance benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by my insurance and I have read and received a copy of the office financial policies. I hereby authorize the doctors to release all information necessary to secure the payment of benefits.
I also authorize the release of medical information to my children's school/daycare upon my or their request.
I also authorize this office to administer the vaccines my child needs and/or are recommended to him/her/them.
I understand that my consent for all of the above is valid for one year after the date of this consent.

______________________________ Responsible Party Signature

____/____/________ Date

Step-Parent Authorization

(*If a step-parent is involved) Step Parent's Name:

I authorize the above-named step parent to: (check all that apply)

☐ bring my child in for treatment ☐ discuss my child's care with our office

______________________________ Signature of Parent/Legal Guardian

____/____/________ Date

Updated Dec. 2020