SHADED SECTIONS ARE FOR OFFICE USE ONLY

GUARANTOR ACCT. NO. _____

R/V BY: _____ DATE _____

Ins checked/ √ every 3 mths.
(for office use only)

LIST ALL CHILDREN'S FIRST & LAST NAME (IF CURRENT PATIENTS HERE)	**M/F**	**DOB**	**DR.**	**ACCOUNT#**	**PCP**	**DENTAL**
					☐	( ) ( )
					☐	( ) ( )
					☐	( ) ( )
					☐	( ) ( )
					☐	( ) ( )
					☐	( ) ( )

☐ Please check box if address below is child's primary residence.

*__PARENT'S NAME:__ _____

DATE OF BIRTH: _____ SS# _____

ADDRESS: _____

_____

PHONE: (H) _____ (C) _____

PARENT'S EMPLOYER _____

PHONE: (W) _____

E-MAIL: _____

☐ Please check box if address below is child's primary residence.

*__PARENT'S NAME:__ _____

DATE OF BIRTH: _____ SS# _____

ADDRESS: _____

_____

PHONE: (H) _____ (C) _____

PARENT'S EMPLOYER _____

PHONE: (W) _____

E-MAIL: _____

EMERGENCY CONTACT PERSON: _____ **Phone #:** _____

***Name of person who holds Primary or 1st Insurance:** _____ **Copies of Insurance Cards**

Person who holds secondary Insurance (if any)**:** _____

Please check with the receptionist to see if your company is one we participate with or not.

If you have coverage with a company that we do not have a contract with, you are responsible for payment at the time of service. It will be your responsibility to submit your claim to that insurance company.

If you do not have insurance, you will be billed directly for payment of services. We accept checks, cash and most credit cards. If you would like to set up a payment plan, please contact the business office. If you are a custodial parent, by law you are ultimately responsible for payment of your child's medical bills, unless otherwise written. Our agreement to care for your child is made with you.

By signing below, I authorize that I have received a copy of Pediatric Medicine's HIPAA statement, payment of medical benefits may be made to the physician or supplier for services rendered, and that Pediatric Medicine may release any medical or other information necessary to process claims. I also understand and agree that I am responsible for the balance of my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status.

→ **PATIENT'S/AUTHORIZED PERSON'S SIGNATURE:**_____ **DATE:** _____