

**PEDIATRIC PARTNERS, LLC**

**You must present your child's insurance card (and secondary card, if applicable) at every visit. A copy of your insurance card is required for us to bill your insurance company. Co-payments are due upon check-in or you will be billed a \$10.00 service fee.**

**LAST NAME ONLY OF ALL PATIENTS HERE:** \_\_\_\_\_

Home Address: \_\_\_\_\_ City and Zip code: \_\_\_\_\_

Primary Contact Phone Number: \_\_\_\_\_ \*Patient's Cell Number if Over 17yrs: \_\_\_\_\_

**PLEASE LIST FULL NAME OF ALL CHILDREN THAT ARE PATIENTS HERE:**

1<sup>st</sup> Child \_\_\_\_\_ M or F Date of Birth: \_\_\_\_\_

2<sup>nd</sup> Child \_\_\_\_\_ M or F Date of Birth: \_\_\_\_\_

3<sup>rd</sup> Child \_\_\_\_\_ M or F Date of Birth: \_\_\_\_\_

4<sup>th</sup> Child \_\_\_\_\_ M or F Date of Birth: \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_ **Policy Holder's Name:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ **Policy Holder's Name:** \_\_\_\_\_

**\*\*All Medical Assistance plans are always secondary to any private health insurance plan your child may have. Please present both insurance cards if applicable, failure to present both cards may result in your child being discharged from our practice.**

**PARENT/ GUARDIAN INFORMATION:**

**Father's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Address: \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

(If different from patient)

City, State, Zip code: \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

Occupation: \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Address: \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

(If different from patient)

City, State, Zip code: \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

Occupation: \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

\*Frequently checked E-mail address to receive reminders/ notifications: \_\_\_\_\_

**EMERGENCY CONTACT (OTHER THAN A PARENT):** Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Cell or Work Phone:** \_\_\_\_\_

**\*I certify the above information is correct to the best of my knowledge. My signature below indicates that I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. I understand it is my responsibility to present all health insurance cards in effect at the time of service, or I may be responsible for all charges.**

**\*I give Pediatric Partners, LLC permission to contact me by telephone and/or to leave a message on my answering machine. Please cross out one or both of the previous statements if you do not approve this. I have been offered a copy of the Notice of Privacy Practice (HIPPA).**

**\*I authorize Pediatric Partners, LLC to release medical information as it is necessary to bill my insurance carrier. I authorize my insurance carrier to release payments of insurance benefits to Pediatric Partners, LLC.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**\*PLEASE READ AND SIGN THE NEXT PAGE**

**2012**