PATIENT INFORMATION

NAME:_____SOC. SEC. #:_____
Last First Middle

DATE OF BIRTH:_____ SEX: Male_____Female_____ AGE:_____ HOME PHONE:_____

ADDRESS:_____e-mail address:_____

CITY:_____STATE:_____ZIP:_____

MOTHER'S NAME:_____DATE OF BIRTH:_____ Cell #::_____

FATHER'S NAME:_____DATE OF BIRTH:_____ Cell #::_____

PATIENT'S CELL # (if over 13):_____

SS #: Mother_____Father_____

WORK #: Mother_____Father_____PHARMACY NAME:_____PHARM PHONE:_____

How did you hear about us? Patient Referral_____Website_____Insurance Co._____Other_____

We make every attempt to contact parents first in an emergency.
If either parent cannot be contacted, I give permission to the following people to make a decision for my child's care:

_____

EMERGENCY CONTACT (other than child's parents):_____

Relationship to patient_____ EMERGENCY CONTACT PHONE #:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to **Advanced Pediatrics**, all insurance benefits otherwise payable to me for services rendered and medical supplies. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Advanced Pediatrics complies strictly with HIPAA regulations for patient privacy.

_____ _____ _____
Signature Relationship Date

PRIMARY INSURANCE

PERSON WHO PATIENT IS INSURED UNDER:_____RELATIONSHIP TO PATIENT:_____
Last First

DATE OF BIRTH:_____ SOC. SEC. #:_____ HOME PHONE:_____

HOME ADDRESS (if different from patient):_____

CITY:_____STATE:_____ZIP:_____

Fill out only if insurance card not available

INSURANCE COMPANY:_____CONTACT PERSON:_____

ID #:_____ GROUP #:_____

SECONDARY INSURANCE (If applicable)

PERSON WHO PATIENT IS INSURED UNDER:_____RELATIONSHIP TO PATIENT:_____
Last First

DATE OF BIRTH:_____ SOC. SEC. #:_____ HOME PHONE:_____