

PATIENT INFORMATION

Name _____ Social Security # _____
 Home Address _____ Date of Birth _____
 _____ Sex: Male/Female (circle) Married/Unmarried (circle)
 Phone # _____ E-mail _____
 Relation to guarantor: (Child, Special dependent, Other-please explain) circle one Other: _____

PRIMARY PARENT OR RESPONSIBLE PARTY INFORMATION (GUARANTOR)

Name _____ Social Security # _____
 Home Address _____ Date of Birth _____
 (if different from pt) _____ Marital Status (Married, Single, Divorced, Separated) circle
 Home phone # _____ Number of Dependents _____
 Work # _____ Names of other kids _____
 Employer _____ Number of insurance policies _____

ADDITIONAL PARENT OR GUARDIAN INFORMATION

Name _____ Social Security # _____
 Home Address _____ Date of Birth _____
 (if different from pt) _____ Marital Status (Married, Single, Divorced, Separated) circle
 Home phone # _____ Sex: Male or Female
 Employer _____ Work # _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy or ID# _____
 Insurance Co. Address _____ Group # _____
 Address _____ Relation to patient _____
 Insurance Co. phone # _____ Date of Birth _____
 Insured Name _____ Sex: Male or Female (circle)
 Secondary Insurance Co. _____ Policy or ID# _____
 Insurance Co. Address _____ Group # _____
 Address _____ Relation to patient _____
 Insurance Co. phone # _____ Date of Birth _____
 Insured Name _____ Sex: Male or Female (circle)

I hereby authorize my insurance benefits to be paid directly to Pediatric Health Associates, P.C. and authorize them to release information as required. I understand that I am responsible to pay all my co-payments and non-covered services at the time of visit as per the FINANCIAL POLICY.

Signature _____ Date _____

_____ Phone Number _____ Relationship to Patient _____

Emergency Contact