



- Update
- New Patient
- Insurance Change
- Address Change

Today's Date _____/_____/_____

Primary Physician in this Office _____

Patient Name _____ Date of Birth _____/_____/_____ Male Female
 (Last) (First) (M.I.)

Address _____ City _____ State _____ Zip _____

Home # _____ Primary E-Mail _____

Parent Name _____

Address _____

City _____ State _____ Zip _____

Cell # _____ Work # _____

Employer _____ Occupation _____

SS # _____ D.O.B. _____/_____/_____

Parent Name _____

Address _____

City _____ State _____ Zip _____

Cell # _____ Work # _____

Employer _____ Occupation _____

SS # _____ D.O.B. _____/_____/_____

Parents are: Living Together Separated Divorced If Divorced/Separated with whom does the child reside? _____

Emergency Contact Person: _____ Relationship _____ Phone # _____

Names of individuals, (other than parents) of persons whom I give permission to bring in my child and be responsible for carrying out the directions given to them by The Pediatric Center. Please note that the person bringing in the child is responsible for payment.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

INSURANCE INFORMATION

(You must provide us with a copy of your current insurance card/s)

Primary Policy Holder _____

Insurance Co. _____

Policy # _____

Group # _____ Co-Pay \$ _____

Relationship to Patient _____

Insurance through: Employer Self Pay Other

Secondary Policy Holder _____

Insurance Co. _____

Policy # _____

Group # _____ Co-Pay \$ _____

Relationship to Patient _____

Insurance through: Employer Self Pay Other

Authorization of Treatment and Assignment of Benefits:

I authorize The Pediatric Center, to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to The Pediatric Center, for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse The Pediatric Center for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my benefits. I also understand that I am responsible for advising The Pediatric Center of any and all changes to my address and/or insurance. Payments of co-pays are due on the date of service. Failure to pay your co-pay at the time of service will result in an additional billing fee of \$10.00. Our office requires 24 hours notice of appointment cancellation. Failure to provide this notice will incur a \$50.00 cancellation fee. Any urgent school, camp or medication form needed within one week can be picked up for a \$20.00 fee.

Signature _____ Relationship _____ Date _____/_____/_____