Date:_______________________________________
Patient Name:________________________________ Relationship to Guarantor:____________________________________
Date of Birth:_______________________ Sex: M______F_______ Social Security Number:______________________________
Home Address:____
City:_________________________________State:___________________________Zip Code:_______________________________
Home Telephone:(______)_________________________Referred By:____
Next of kin(not living at address listed above):____________________________Relationship:_______________________
Address:____

Siblings: Name Sex DOB Health Condition

____
____
____
____
____

Father's Name:____ Date of Birth:_______________________________
Home Address:(if different)____
City:____________________________________State:__________________________Zip Code:______________________________
Home Telephone:(____)________________Work Telephone:(____)_________________Cell Phone:(____)____________________
Employer:____ Employer Address:____________________________________
Social Security Number:__________________________________ Marital Status:____________________________________

Mother's Name:____ Date of Birth:______________________________________
Home Address:(if different)____
City:____________________________________State:__________________________Zip Code:______________________________
Home Telephone:(____)________________Work Telephone:(____)_________________Cell Phone:(____)____________________
Employer:____ Employer Address:____________________________________
Social Security Number:__________________________________ Marital Status:____________________________________

INSURANCE INFORMATION

Primary Insurance Name:____________________________ Effective Date:_______________________________________
Address:____
City:___________________________________ State:______________________________ Zip Code:__________________________
Telephone Number:____________________________ ID Number:_________________________ Group Number:_________________
Full Name of Insured:____________________________________ Policy Type:______ HMO ______ PPO _____ PPC__Other:_____
If you belong to an HMO, do you also have other Group Insurance Coverage: ____________Yes ____________No
Co-Pay Amount:__________________________
How did you hear about us?____
Previous Physician:____

NOTIFY IN CASE OF EMERGENCY!!

Name: ______________________________________Relationship:_____________________________ Phone:(_____)___________
Name: ______________________________________Relationship:_____________________________ Phone:(_____)___________
Name: ______________________________________Relationship:_____________________________ Phone:(_____)___________

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to PediDocs to release any pertinent information to my insurance company upon request, and I also authorize payment directly to PediDocs. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature:____ Date:______________________ Witness:_________________________

Credit Card Authorization

I authorize PediDocs to charge the credit card below for any charges not paid within 15 days of my visit.
Credit Card Number:_____________________________Exp Date:___________________________________Signature:__________________________________

I have reviewed and agree to the HIPPA Privacy Policy and Financial Policy.

Signature:____ Date:______________________ Witness:_________________________