Patient Information

(Please complete this entire form)

Date_____

Patient and Sibling Data (please list **all** children below)

Name	Date of birth	Name	Date of Birth

Insurance Information:

Financially Responsible/Primary card holder's relationship to our patient(s): ___Mother ___Father ___Legal Guardian

Last Name_____ First Name_____ Date of Birth_____

Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

Occupation_____ Employer_____

Insurance Name_____ Insurance Address_____

ID Number_____ Effective Date_____

Group Number _____ Primary holder's Social Security Number_____

Other Parent:

___ Mother ____ Father ____ Legal Guardian

Last Name_____ First Name_____ Date of Birth_____

Address_____

Home Phone_____ Work Phone_____ Cell Phone_____

Occupation_____ Employer_____

Patient Authorization

Our policy is payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, money order or credit card.

I have read the Notice of Privacy Practices provided upon request by Pediatric and Adolescent Care, PA

Date_____ **Signature**_____