PEDIATRIC AFFILIATES, P.A.

SPECIALIZING IN INFANTS, CHILDREN, & ADOLESCENT MEDICINE

Last Name: _____ **Please list ALL children who are patients**

Patient Name	M/F	SSN	DOB	Address, City, State, Zip	Individual Patient Insurance #

MOTHER'S Information **Emergency Contact? Yes No**

Name _____

DOB _____ **SSN** _____

Address _____

City/State _____

Home Phone _____

Cell Phone_____

Employer _____

Work Phone _____

Email Address _____

FATHER'S Information **Emergency Contact? Yes No**

Name _____

DOB _____ **SSN** _____

Address _____

City/State _____

Home Phone _____

Cell Phone_____

Employer _____

Work Phone_____

Email Address _____

PRIMARY INSURANCE - **Insurance Carrier** _____ **Subscriber**_____

Policy #_____**Group #**_____ **Eff. Date**_____

SECONDARY INSURANCE - **Insurance Carrier** _____ **Subscriber**_____

Policy #_____**Group#**_____**Eff. Date**_____

*****PERSON RESPONSIBLE for payment after insurance**_____

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

We are committed to providing you with the best possible care. As medical care providers, our relationship is with you and not the insurance company. However, we are also anxious to help you receive the maximum allowable insurance benefits. Some insurance companies arbitrarily select certain services that they will not cover. Therefore, you are liable for any deductible, co-insurance, co-pay, and any non-covered expenses. Your signature below authorizes PEDIATRIC AFFILIATES, P.A. to submit claims on your child's behalf and to release any medical information and or records requested by your insurance company.

Parent/Guardian Signature_____ **Date**_____