PediatriCare Associates
Pediatric and Adolescent Medicine

Patients Name: _____ DOB: _____ M / F

Patients Name: _____ DOB: _____ M / F

Patients Name: _____ DOB: _____ M / F

Patients Name: _____ DOB: _____ M / F

Referred By: _____

Race: _____ Language: _____ Ethnicity: Latino / Non-Latino

Address: _____ City: _____

State: _____ Zip: _____ Best Contact Number: _____

Father: (first) _____ (last) _____

DOB: _____ SSN: _____ E-Mail Address: _____

Address: _____

Phone: _____ Cell: _____

Employer Name &Address: _____

Mother: (first) _____ (last) _____

DOB: _____ SSN: _____ E-Mail Address: _____

Address: _____

Phone: _____ Cell: _____

Employer Name &Address: _____

PRIMARY INSURANCE

Insurance Co.: _____ Insured's Name: _____

Member #: _____ Group #: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone #: _____

I hereby authorize the release of medical records to my insurance company, as may be necessary for the purpose of reimbursement. I realize that I am ultimately responsible for any and all services rendered to me (my child) regardless of any insurance determinations.

Signature: _____ Date: _____

*** It is our policy that this form be completed on a yearly basis ***