



Pediatric Care Associates

Pediatric and Adolescent Medicine

Date: _____

Patients Name: _____ D.O.B: _____ M/F

Patients Name: _____ D.O.B: _____ M/F

Patients Name: _____ D.O.B: _____ M/F

Patients Name: _____ D.O.B: _____ M/F

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

Father: (first) _____ (last) _____

D.O.B: _____ SSN: _____

Address (if different than child) _____

Home # _____ Cell # _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Mother: (first) _____ (last) _____

D.O.B _____ SSN: _____

Address (if different than child) _____

Home # _____ Cell # _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____

PRIMARY INSURANCE

Insurance Co Name: _____

Member # _____

Group # _____

Insured's Name: _____

Relationship to the patient: _____ D.O.B _____

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 office policy that this form be completed on a yearly basis***