PediatriCare Associates
Pediatric and Adolescent Medicine

List all children please

Child's Name: _____ DOB: _____ M / F

Child's Name: _____ DOB: _____ M / F

Child's Name: _____ DOB: _____ M / F

Child's Name: _____ DOB: _____ M / F

Referred By: _____ Race: _____ Ethnicity: Latino / Non-Latino

Language: _____ **Best Contact Number:** _____

Address: _____

PARENT/GUARDIAN INFORMATION

(circle one)

Mother/Father/Guardian: (first name) _____ (last name) _____

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

Address: _____

Phone: _____ Cell: _____

Employer Name & Address: _____

(circle one)

Mother/Father/Guardian: (first name) _____ (last name) _____

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

Address: _____

Phone: _____ Cell: _____

Employer Name & Address: _____

PRIMARY INSURANCE

Insurance Co.: _____ Insured's Name: _____

Member #: _____ Group #: _____

EMERGENCY CONTACT (other than parents)

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 *****

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