☐ Update

☐ New Patient

Today's Date____/____/____

Patient Name_____ Date of Birth____/____/____ M F

*please check one of each category below

Race: Refused to Report__ Undefined___ American Indian___ Asian__ Black/African American__ Native Hawaiian or Pacific Islander __ White___

Ethnicity: Hispanic or Latino__ Not Hispanic or Latino__ Refused to report/Unreported____

Language:_____

Birth place:_____State or Country

Patient Name_____ Date of Birth____/____/____ M F

*please check one of each category below

Race: Refused to Report__ Undefined___ American Indian___ Asian__ Black/African American__ Native Hawaiian or Pacific Islander __ White___

Ethnicity: Hispanic or Latino__ Not Hispanic or Latino__ Refused to report/Unreported____

Language:_____

Birth place:_____State or Country

Address_____ City_____
State_____ Zip_____

Home # _____ Primary E-Mail_____

Parent Name_____
Address_____
City_____ State_____ Zip_____
Cell #_____ Work #_____
Employer _____ Occupation_____
D.O.B.____/____/____

Parent Name_____
Address_____
City_____ State_____ Zip_____
Cell #_____ Work #_____
Employer _____ Occupation_____
D.O.B.____/____/____

INSURANCE INFORMATION

(You must provide us with a copy of your current insurance card/s)

Primary Policy Holder_____
Insurance Co._____
Policy #_____
Group #_____ Co-Pay $_____
Relationship to Patient_____
Insurance through: Employer Self Pay Other

Secondary Policy Holder_____
Insurance Co._____
Policy #_____
Group #_____ Co-Pay $_____
Relationship to Patient_____
Insurance through: Employer Self Pay Other

Authorization of Treatment and Assignment of Benefits:

I authorize The Pediatric Center, to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms, school & camp forms. I authorize payment directly to The Pediatric Center, for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse The Pediatric Center for any payments my insurance company may have sent to me in error. I understand that I am financially responsible for all co-payments and any charges not covered under my benefits. I also understand that I am responsible for advising The Pediatric Center of any and all changes to my address and/or insurance.

Signature_____ **Relationship**_____ **Date**____/____/____

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