Pediatric Services
OF SPRINGFIELD

New Patient/Transfer Patient Information

Please return to: medrecords@pediatricservices.org

PATIENT INFORMATION

Patient full name: _____

Patient DOB:_____ **Sex/Gender: [M] [F]**

Patient address:_____

City:_____**State:**_____**Zip code:**_____ **Primary Language:** _____

Patient email (18+): _____**Patient phone** (18+):_____

Do you have a sibling who is a patient of Pediatric Services? If yes, Name:_____ **DOB:** _____

PRIMARY PARENT/GUARDIAN

Name: _____

Address: [ ] Check if address is the same as above

_____

City:_____**State:**___**Zip code:**_____

Email: _____

Phone (H):_____

(C):_____

[ ] Check if this party is responsible for bills.

SECONDARY PARENT/GUARDIAN

Name: _____

Address: [ ] Check if address is the same as above

_____

City:_____**State:**___**Zip code:**_____

Email: _____

Phone (H):_____

(C):_____

[ ] Check if this party is responsible for bills.

PRIMARY INSURANCE INFORMATION

Insurance company: _____**Policy #:**_____**Group #:**_____

Policy holder name:_____ **Policy holder DOB:**_____

SECONDARY INSURANCE INFORMATION

Insurance company: _____**Policy #:**_____**Group #:**_____

Policy holder name:_____ **Policy holder DOB:**_____

FINANCIAL OBLIGATION

[ ] ***I understand all insurance co-pays are due at the time of service.***

[ ] ***I understand it is my financial responsibility for all services rendered that are not covered/paid for by primary/seconadry insurance.***

[ ] ***I understand and agree to the late/no show policy. I understand I am subject to a late/no show service charge of $25.00. Details about the late/no show policy may be found on www.pediatricservices.org.***

Signature of financially responsible parent/guardian: _____ **Date:** _____