PATIENT INFORMATION FORM

CHILD'S INFORMATION

Name_____DOB:_____Sex: M F Phone:_____

Address:_____City:_____State:_____Zip:_____

Primary insurance: _____Certificate #:_____

Secondary insurance:_____Certificate#:_____

MEDICAID OR AFDC RECIPIENTS

Card #:_____

FATHER'S INFORMATION

Name_____DOB:_____Phone: _____

Address:_____City:_____ State:_____Zip:_____

Place of Work:_____Work Phone #_____

Insurance:_____Group#:_____

MOTHER'S INFORMATION

Name_____DOB:_____Phone:_____

Address:_____City:_____State:_____Zip:_____

Place of Work:_____Work Phone #_____

Insurance:_____Group#:_____

Who is responsible for the child's bill:_____Referred by:_____

Emergency name and number (other then parent)_____

AUTHORIZATION

I authorize Pediatric Associates to release medical information to my insurance carrier and other physicians requesting information on my behalf. I also authorize payment directly to Pediatric Associates for any services rendered to my child. I also attest that I am the parent/legal guardian and I am responsible for any charges incurred at the time of my child's visit. I have reviewed all information on this form and it is correct. I am responsible for a co-payment and if I do not pay at the time of service I understand that there may be $10 billing cost added to the co-payment charge.

I understand that my insurance company provides coverage for medically necessary services for their members. However, it is my responsibility to make certain that a physician in this practice is listed as my primary care physician for my child. I acknowledge responsibility for payment of this service if not covered by my insurance company.

_____ _____

Signature of parent/legal guardian Date

851 MIDDLE STREET • FALL RIVER, MA 02721 • TEL 508-324-6800 • FAX 508-674-5440 • www.pedsfrma.com