VERRAS PEDIATRICS, P.C.
PEDIATRIC & ADOLESCENT MEDICINE

VERRAS PEDIATRICS, PC

Patient Name _____ **M / F** **Date of Birth** _____

Father's Name _____ **Social Security #** _____ **Date of Birth** _____

Employer _____ **Employer Phone #** _____

Mother's Name _____ **Social Security #** _____ **Date of Birth** _____

Employer _____ **Employer Phone #** _____

Home Address _____ **Cell Phone #** _____

City _____ **State** _____ **Zip** _____ **Home Phone #** _____

Emergency Contacts

In case of emergency contact: Name _____
Phone _____ **Relation** _____
Address _____ **City** _____ **State** _____ **Zip** __
*******It is UNLAWFUL not to disclose ALL insurance information*******Parent initials** _____

Insurance Information

Primary Insurance

Name _____

Insured Name _____

Relation to Patient _____

Policy Number _____

Group Number _____

Secondary Insurance

Name _____

Insured Name _____

Relation to Patient _____

Policy Number _____

Group Number _____

Other Children

Name _____ **M / F** **Name** _____ **M / F**

Name _____ **M / F** **Name** _____ **M / F**

Consent of Medical Care, Immunizations, Minor Procedures and Assignment of Benefits

I authorize Verras Pediatrics to provide medical care for my child/children. I authorize payment of medical benefits directly to Verras Pediatrics for services provided. I authorize physician to release any information required to process my claims.

Signature _____ **Date** _____

I give my consent for my Doctor to administer their recommended immunizations, any therapeutic injections that are necessary, and to perform any minor procedures after discussing it with the parent and or patient.

Fathers signature _____ **Mothers signature** _____