



Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Relationship to Guarantor: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Telephone: (\_\_\_\_) \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Next of kin(not living at address listed above): \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_

| Siblings: | Name | Sex | DOB | Health Condition |
|-----------|------|-----|-----|------------------|
|           |      |     |     |                  |
|           |      |     |     |                  |
|           |      |     |     |                  |
|           |      |     |     |                  |

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Address:(if different) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Telephone:(\_\_\_\_) \_\_\_\_\_ Work Telephone:(\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Address:(if different) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Telephone:(\_\_\_\_) \_\_\_\_\_ Work Telephone:(\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Full Name of Insured: \_\_\_\_\_ Policy Type: \_\_\_\_\_ HMO \_\_\_\_\_ PPO \_\_\_\_\_ PPC \_\_\_\_\_ Other: \_\_\_\_\_  
 If you belong to an HMO, do you also have other Group Insurance Coverage: \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Co-Pay Amount: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 Previous Physician: \_\_\_\_\_

**NOTIFY IN CASE OF EMERGENCY!!**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

I understand that payment of all medical care is due at the time of service. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to PediDocs to release any pertinent information to my insurance company upon request, and I also authorize payment directly to PediDocs. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Credit Card Authorization**

I authorize PediDocs to charge the credit card below for any charges not paid within 15 days of my visit.  
 Credit Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**I have reviewed and agree to the HIPPA Privacy Policy and Financial Policy.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_