



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: _____