PEDIATRIC HEALTH CENTER

PATIENT NAME _____ SEX _____ DOB _____
(FIRST) (MIDDLE) (LAST)

NAME YOU CALL YOUR CHILD_____

FATHER'S NAME_____DATE OF BIRTH_____
S.S.#_____EMPLOYER_____OCCUPATION_____
EMP. ADDRESS_____EMP. PHONE_____
CITY_____STATE_____ZIP CODE_____PGR/CELL #_____

HOME ADDRESS_____HOME PHONE #_____
CITY_____COUNTY_____STATE_____ZIP CODE_____

MOTHER'S NAME_____DATE OF BIRTH_____
S.S.#_____EMPLOYER_____OCCUPATION_____
EMPLOYEE ADDRESS_____EMP. PHONE_____
CITY_____STATE_____ZIP CODE_____PGR/CELL#_____

HOME ADDRESS_____HOME PHONE_____
CITY_____COUNTY_____STATE_____ZIP CODE_____
EMAIL ADDRESS _____

IN CASE OF EMERGENCY PLEASE CONTACT (someone other than parent):
NAME_____RELATIONSHIP_____PHONE#_____

INSURANCE INFORMATION

1. INSURANCE COMPANY_____GROUP#_____
INSURED'S NAME_____I.D.#_____
DATE OF BIRTH_____ IS THIS INS. THROUGH YOUR EMPLOYER? _____
2. INSURANCE COMPANY_____GROUP#_____
INSURED'S NAME_____I.D.#_____
DATE OF BIRTH_____ IS THIS INS. THROUGH YOUR EMPLOYER? _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC HEALTH CENTER OF ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, FOR HIS SERVICES PROVIDED FOR MY CHILD WHICH YOUR OFFICE MAY FILE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION. I UNDERSTAND THAT IF A BALANCE ON THIS ACCOUNT IS UNPAID AFTER THIRTY (30) DAYS ON OFFICE VISITS OR SIXTY (60) DAYS ON HOSPITAL CHARGES, I AM RESPONSIBLE FOR ALL COLLECTION FEES INCURRED IN ORDER TO COLLECT THE BALANCE. ALL OFFICE VISITS AND SERVICES ARE DUE AND PAYABLE AT TIME OF SERVICE, UNLESS, OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR VISIT. I UNDERSTAND THAT ALL CONTRACTED INSURANCE CLAIMS WILL BE FILED, BUT THE GUARANTOR IS ULTIMATELY RESPONSIBLE FOR ALL FEES INCURRED. I HEREBY AUTHORIZE RELEASE OF ANY RECORDS/ INFO FROM PREVIOUS AND REF HOSPITALS/PROVIDERS TO PHC NECESSARY FOR MEDICAL TREATMENT OR TO PROCESS ANY CLAIMS FILED ON MY CHILD'S BEHALF.

SIGNATURE_____DATE_____
PARENT OR LEGAL GUARDIAN