

Pediatric Associates, Inc.

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PRIMARY Guarantor (Insured Party)

Last Name: _____ First Name: _____ MI: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Date of Birth: _____ - _____ - _____ SS#: _____ - _____ - _____ Sex: M / F
 PHONE Home: _____ Cell: _____ Work: _____

SECONDARY Guarantor (Insured Party)

Last Name: _____ First Name: _____ MI: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Date of Birth: _____ - _____ - _____ SS#: _____ - _____ - _____ Sex: M / F
 PHONE Home: _____ Cell: _____ Work: _____

Child's Name(s):

	LAST	FIRST	MI	DATE OF BIRTH
1)	_____	_____	_____	_____-_____-_____ _____-_____-_____
2)	_____	_____	_____	_____-_____-_____ _____-_____-_____
3)	_____	_____	_____	_____-_____-_____ _____-_____-_____
4)	_____	_____	_____	_____-_____-_____ _____-_____-_____
5)	_____	_____	_____	_____-_____-_____ _____-_____-_____
6)	_____	_____	_____	_____-_____-_____ _____-_____-_____

#of Dependents: _____ Marital Status: _____ Which parent does the child reside with? _____

of Ins Plans: _____ 1) Ins Co: _____ 2) Ins Co: _____

Father's Name: _____ Father's Place of Employment: _____

PHONE Work: _____ Cell: _____ SS#: _____ - _____ - _____ DOB: _____

Mother's Name: _____ Mother's Place of Employment: _____

PHONE Work: _____ Cell: _____ SS #: _____ - _____ - _____ DOB: _____

Nearest Relative NOT living with you: _____ Phone: _____

Nearest Friend NOT living with you: _____ Phone: _____

Pediatric Associates, Inc. uses a telephone appointment reminder system. May we leave a message at your home to remind you of an appointment? YES / NO

I hereby authorize Pediatric Associates, Inc and/or any of its representatives to disclose records obtained on the course of my diagnosis and to any government and/or third part private payers, or any other entity required by law. I further authorize the disclosure of my diagnosis and treatment records, including the charges for the same to any billing agency, attorney, or debt collection agency selected by Pediatric Associates for the collection of charges incurred for treatment provided by Pediatric Associates, Inc. I understand that if complete insurance information provided that every reasonable effort to collect from my insurance company will be made. I realize that I should contact my insurance company