

Pediatric Associates, Inc.

www.kidzdoc.com

PRIMARY Guarantor (Insured Party)

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

SECONDARY Guarantor (Insured Party)

Last Name: _____ First Name: _____ MI: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Date of Birth: ____ - ____ - ____ SS#: ____ - ____ - ____ Sex: M
 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#: ____ - ____ - ____ DC
 Mother's Name: _____ Mother's Place of Employment: _____
 PHONE Work: _____ Cell: _____ SS #: ____ - ____ - ____ DC

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 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 to any government and/or third part private payers, or any other entity required by law. I further authorize the disclosure of my diagnosis treatment records, including the charges for the same to any billing agency, attorney, or debt collection agency selected 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 to ensure timely payment. If my insurance company fails to pay or pays only a portion of the bill after 90 days I am responsible for prompt payment of any remaining balance. Financial responsibility for the bill remains with me until full payment is made.

Signature Parent/Guardian: _____ Date: _____