

Referred by: _____

Parent/Guardian Information

Father's Name:(last) _____
First : _____ Middle initial: _____
Mailing Address: _____
City _____ State _____
Zip _____
Employer _____ Title _____

Home Ph.# _____
Office _____ Cell Ph. # _____
E-mail _____
Date of Birth (M/D/Y) _____
Social Security # _____
Marital Status (circle one) S M D W

Mother's Name:(last) _____
First : _____ Middle initial: _____
Mailing Address: _____
City _____ State _____
Zip _____
Employer _____ Title _____

Home Ph.# _____
Office _____ Cell Ph. # _____
E-mail _____
Date of Birth (M/D/Y) _____
Social Security # _____
Marital Status (circle one) S M D W

Children (List all children; oldest first, that are patients here.)

Name: Last	First	Middle	Called by:	DOB (m/d/y)	Sex (M/F)
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____

Insurance Information

Primary Insurance: _____
Group Number: _____
Policyholder's date of birth: _____
Policyholder's employer: _____
Policyholder's address: _____, City: _____
Patients relationship to policyholder: (circle one) self

Policy Number: _____
Policyholder's Name: _____
Policyholder's SS #: _____
Employer's Ph#: _____
State: _____, Zip: _____
spouse child grandchild step-child

Secondary Insurance: _____
Group Number: _____
Policyholder's date of birth: _____
Policyholder's employer: _____
Policyholder's address: _____, City: _____
Patients relationship to policyholder: (circle one) self

Policy Number: _____
Policyholder's Name: _____
Policyholder's SS #: _____
Employer's Ph#: _____
State: _____, Zip: _____
spouse child grandchild step-child

By signing below, I authorize the release of any medical information necessary to process all claims. I hereby authorize Associates in Pediatric and Adolescent Medicine to apply for benefits on my behalf for covered services. I request that payment be made directly to Associates in Pediatric and Adolescent Medicine (Dr's Eloffson, Fakouri, Perilloux, et al.) I understand that whatever the insurance does not pay (excluding usual and customary) will be my responsibility to pay.

Date: _____

Signature: _____

By signing this form you acknowledge that whoever you have bringing in your child for treatment can review this form for correctness.