MAPLE AVENUE PEDIATRICS, PA – PATIENT INFORMATION FORM

PLEASE READ CAREFULLY AND FILL OUT ***ALL*** FIELDS

PLEASE LIST THE NAMES OF ***ALL*** CHILDREN COVERED BY THE ***BELOW*** INSURANCE INFORMATION

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

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LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

LAST NAME: _____ FIRST NAME: _____ DOB: _____ SEX: M___ F_____

PARENT OR LEGAL GUARDIAN #1: THIS PERSON AUTHORIZES TREATMENTS, ACCEPTS FINANCIAL RESPONSIBILITY, AND RECEIVES BILLING STATEMENTS

RESPONSIBLE PARENT NAME _____RELATION TO PATIENT: ____ Mom ____ Dad ____Legal Guardian

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CONTACT # ☐ HOME: _____ ☐ CELL: _____ ☐ WORK: _____

E-MAIL: _____

OCCUPATION: _____ EMPLOYER NAME: _____

PARENT OR LEGAL GUARDIAN #2

PARENT NAME _____ RELATION TO PATIENT: _____ Mom _____ Dad ____ Legal Guardian

DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

CITY: _____STATE:_____ZIP CODE: _____

CONTACT # ☐ HOME: _____ ☐ CELL: _____ ☐ WORK: _____

E-MAIL: _____

OCCUPATION: _____ EMPLOYER NAME: _____

CHILDREN PRIMARILY LIVE WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER _____

EMERGENCY CONTACT PERSON: _____ PHONE # _____

ADDRESS: _____ RELATIONSHIP: _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____LABORATORY: _____

STREET ADDRESS _____ CITY_____ STATE_____ ZIP_____

MEMBER ID # _____ EFFECTIVE DATE _____ COPAY_____

TYPE OF COVERAGE_____ GROUP # _____

NAME OF POLICY HOLDER: _____ D.O.B OF POLICY HOLDER _____

SIGNATURE ON FILE: I hereby authorize release of information to my insurance company and assign benefits otherwise payable to me, to the doctor indicated on the claim. I understand that I am financially responsible for all charges, including collection fees. NOTE: It is our policy to file insurance ONLY when we are a participating provider in a specific insurance plan. However, we need a signature on file for all patients. We do not submit to secondary insurance companies.

SIGNATURE _____ **DATE**_____