

2010 FAMILY INFORMATION FORM

Patient/Child #1's Name: Last/First	Birth Date ____/____/____	M/F	Cell#
Patient/Child #2's Name: Last/First	Birth Date ____/____/____	M/F	Cell#
Patient/Child #3's Name: Last/First	Birth Date ____/____/____	M/F	Cell#
Patient/Child #4's Name: Last/First	Birth Date ____/____/____	M/F	Cell#
Father's Name: Last/First	Birth Date ____/____/____	SSN	<input type="checkbox"/> Parent <input type="checkbox"/> Step <input type="checkbox"/> Guardian
Father's Workplace	Father's Work # / Father's Cell		<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated
Mother's Name: Last/First	Birth Date ____/____/____	SSN	<input type="checkbox"/> Parent <input type="checkbox"/> Step <input type="checkbox"/> Guardian
Mother's Workplace	Mother's Work # / Mother's Cell		<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated
Child/Children Reside With: _____			
Child's Address/Phone _____ Home Phone: _____		Insured Address/Phone (if different from child) _____ Home Phone: _____	
Primary Insurance: _____ ID# _____		Secondary Insurance: _____ ID# _____	
Name of Primary Insured/Relationship		Name of Secondary Insured/Relationship	

The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any **deductible** and **co-payment** as determined by your contract with your insurance carrier. **We require these payments at time of service.** Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

I have read the above policy regarding my financial responsibility to **Pediatric Associates**, for providing services to myself or to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pediatric Associates, the full and entire amount of bill incurred by myself or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

There is a \$25.00 fee for missed check-ups or cancellations less than 24 hours.

Signature _____ Relationship to Patient _____ Date _____