

# Pediatric & Medical Associates, PC

Please fill out this form entirely.

## Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ (Best # to Confirm Apts)

Parent 2 Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient** Personal Phone (If Applicable): \_\_\_\_\_

## Primary Physician:

**\*How did you hear about us?\***

## Race: (Please Circle)

Caucasian

Black/African American

American Indian/Alaskan Native

Asian

Native Hawaiian or other Pacific Islander

Other Race: \_\_\_\_\_

**Languages Spoken:** \_\_\_\_\_

## Ethnicity: (Please Circle)

Hispanic

Non-Hispanic

## Insurance Information:

### Primary Insurance:

Insurance: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Secondary Insurance:

Insurance: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Guarantor (Person to be billed)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Gender: \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address (If different from patient): \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_  Patient  Parent  Other: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Patient or Authorized Person's Signature:

I, the undersigned, give my authorization to treat and assign directly to Pediatric & Medical Associates, PC (PMA) all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for the payment of any deductible amounts, coinsurance, or other expenses not paid by insurance, as well as any administrative costs such as missed appointments, rebilling fees, and expenses incurred in attempting to collect balance not paid at time of service, including any finance charge at 1 ½% interest. I understand payment is expected at time of service.

I hereby authorize PMA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: \_\_\_\_\_

Signature Date: \_\_\_\_\_

X \_\_\_\_\_

Please provide current copy of insurance cards at each visit. Thank you.