Pediatric & Medical Associates, PC

Please fill out this form entirely.

Parent Information:

Parent or Guardian #1 Name: _____ Date of Birth:_____
Home Address: _____City: _____ State: _____ Zip Code:_____
Phone Number: _____Cellphone Carrier: _____ Email Address: _____
Parent or Guardian #2 Name: _____ Date of Birth: _____
Home Address: _____City: _____ State: _____ Zip Code:_____
Phone Number: _____Cellphone Carrier: _____ Email Address: _____
Best Number to Confirm Appointments: Parent/Guardian #1 or Parent/Guardian #2
Which Parent/Guardian Should be the Guarantor (Person to be billed)? Parent/Guardian #1 or Parent/Guardian #2

Insurance Information:

Primary Insurance:

Insurance:_____Policy ID:_____Group ID:_____
Policy Holder:_____DOB:_____Relationship:_____

Secondary Insurance (if applicable):

Insurance:_____Policy ID:_____Group ID:_____
Policy Holder:_____DOB:_____Relationship:_____

Preferred Pharmacy Name & Address:_____
***How did you hear about us (If new to our practice)? ***_____

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

Children's Information:

Name:_____Date of Birth:_____Sex: ____Primary Physician: _____
Name:_____Date of Birth:_____Sex: ____Primary Physician: _____
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Name:_____Date of Birth:_____Sex: ____Primary Physician: _____
Name:_____Date of Birth:_____Sex: ____Primary Physician: _____

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.