DELTA PEDIATRICS

PATIENT INFORMATION

Date_____/_____/_____ Male ___ Female ____

Patient's Name: _____
Last First MI

Home Address: _____

Home Phone: (_____) _____

Date of Birth: _____/_____/_____ Age: _____ SS# _____-_____-_____
Mo Day Year

PARENT/GUARDIAN INFORMATION

Mother's Name: _____ Date of Birth: _____/_____/_____
Last First MI

Home Address: _____

Home Phone: (____) _____ Cell Phone: (_____)_____

Email _____

SS#: _____-_____-_____ Employer's Name: _____

Marital Status: Married ____ Single ____ Divorced ____ Separated ____

Father's Name: _____ Date of Birth: _____/_____/_____
Last First MI

Home Address: _____

Home Phone: (____) _____ Cell Phone: (_____)_____

Email_____

SS#: _____-_____-_____ Employer's Name: _____

Marital Status: Married ____ Single ____ Divorced ____ Separated ____

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INSURANCE INFORMATION

Primary Insurance:

Name of Insurance Plan: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

I.D. Number (include alpha prefix): _____

Group Name and Number: _____

Effective Date: _____ Copay Amount: $_____

Secondary Insurance:

Name of Insurance Plan: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

I.D. Number (include alpha prefix): _____

Group Name and Number: _____

Effective Date: _____ Copay Amount: $_____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: ( ) _____

I, _____ acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Delta Pediatrics. I understand that I am responsible for my deductible, coinsurance and any non-covered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize my insurance company to release any medical information necessary to process pending and or unpaid claims, and hereby assign payment of all medical benefits to Delta Pediatrics.

_____/____/_____
Signature Date

How did you hear about us?_____