

Pediatric Partners of Stafford

Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Sex:
Child Resides With (Please list father, mother, both, or other):		

Parent/ Guardian Information

Father's Last Name:	Father's First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Marital Status:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Employer:
Employer Address:	Employer Phone Number:	

Mother's Last Name:	Mother's First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Marital Status:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Employer:
Employer Address:	Employer Phone Number:	

Emergency Contact Information

Name:	Phone Number:	Relationship to Child:
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Insurance Information

Primary Insurance:	Date Insurance Effective:
Policy ID Number:	Group Number:
Policy Holder's Name:	Relationship to Patient:
Policy Holder's Date of Birth:	Policy Holder's Social Security Number:

Secondary Insurance:	Date Insurance Effective:
Policy ID Number:	Group Number:
Policy Holder's Name:	Relationship to Patient:
Policy Holder's Date of Birth:	Policy Holder's Social Security Number:

Assignment of Insurance Benefits:

I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the patient at this practice. I understand that my insurance provided, in no way relieves me of financial responsibility for services rendered now or in the future at this practice.

Guarantee of Payment:

I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now or in the future by this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33% and 1/3 of the amount due, court costs and reasonable attorney's fees incurred by this practice.

Signature of Parent/ Guardian: _____

Date: _____