Pediatric & Medical Associates, PC

Please fill out this form entirely.

Patient Information:

Last Name:_____First Name:_____MI:_____Gender:_____DOB:_____
Address:_____
City:_____State:_____ Zip Code:_____
Email Address:_____
Parent 1 Name:_____Phone:_____(**Best # to Confirm Apts**)
Parent 2 Name:_____Phone:_____
Patient Personal Phone (If Applicable):_____
HOW DID YOU HEAR ABOUT US?_____ Referring Physician:_____

Race: (Circle One)

Caucasian
Black/African American
American Indian/Alaskan Native
Hispanic
Asian
Other Race:_____

Languages Spoken:_____

Ethnicity: (Circle One)

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:_____ City:_____
State:_____ Zip Code:_____Phone Number:_____
Employer Name & Address:_____Occupation:_____

Emergency Contacts

(1) Last Name:_____ First Name:_____
Address:_____City:_____
State:_____Zip Code:_____Relationship:_____Phone Number:_____
(2) Last Name:_____ First Name:_____
Address:_____City:_____
State:_____Zip Code:_____Relationship:_____Phone Number:_____

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 balanced not paid at time of service. 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.