A TO Z PEDIATRICS PC

New Patient Information Record

Patient Name: ____
(Last) (First) (Middle)

Date of Birth: _____/____/_______ Sex: M / F Social Security # ______________________
(mm) (dd) (yyyy)

Address: ____
(Street Address) (Apt) (City) (State) (Zip code)

Parent / Guardian Home Phone: (_____) -______-________ Email Address: ______________________

Parent / Guardian Cell Phone (_____) -_________-__________

Father's Name ______________________________ Date of Birth ______/______/________

Mother's Name ______________________________ Date of Birth ______/______/________

How did you hear about us? ______________________________________

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Insurance Information

Primary Insurance: ______________________Insurance ID:__________________Co Payment $_____

Policy Holder: ______________________________________Effective Date:____/_____/_____
(Last) (First)

Policy Holder's Date of Birth: ______/______/_____ Sex: M / F Relation to patient: Parent / Guardian
(mm) (dd) (yyyy) Circle

Policy Holder's Social Security Number: _____-_____-_______ Insured Employer: ____________________

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Emergency Contact

Name: ______________________________ Relationship: ______________________________
(Last) (First)

Address: ____
(Street Address) (Apt) (City) (State) (Zip code)

Home Phone: (____) -__________-_______ Mobile Phone: (____) -______-________

Authorization: I hereby authorize A to Z Pediatrics P.C. to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether covered or not by insurance.

Signature: ______________________________ Date: _______/______/______
(mm) (dd) (yyyy)