

2012 FAMILY INFORMATION FORM

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|--|---------------------------------|--|--|
| Patient/Child #1's Name: Last/First | Birth Date ____/____/____ | M/F | Cell# |
| Patient/Child #2's Name: Last/First | Birth Date ____/____/____ | M/F | Cell# |
| Patient/Child #3's Name: Last/First | Birth Date ____/____/____ | M/F | Cell# |
| Patient/Child #4's Name: Last/First | Birth Date ____/____/____ | M/F | Cell# |
| Father's Name: Last/First | Birth Date ____/____/____ | SSN | <input type="checkbox"/> Parent <input type="checkbox"/> Step <input type="checkbox"/> Guardian |
| Father's Workplace | Father's Work # / Father's Cell | | <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated |
| Mother's Name: Last/First | Birth Date ____/____/____ | SSN | <input type="checkbox"/> Parent <input type="checkbox"/> Step <input type="checkbox"/> Guardian |
| Mother's Workplace | Mother's Work # / Mother's Cell | | <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated |
| Child/Children Reside With: _____ | | | |
| Child's Address/Phone _____ Home Phone: _____ | | Insured Address/Phone (if different from child) _____ Home Phone: _____ | |
| Primary Insurance: _____ ID# _____ | | Secondary Insurance: _____ ID# _____ | |
| Name of Primary Insured/Relationship | | Name of Secondary Insured/Relationship | |

The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any **deductible** and **co-payment** as determined by your contract with your insurance carrier. **We require these payments at time of service.** Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

I have read the above policy regarding my financial responsibility to **Pediatric Associates**, for providing services to myself or to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pediatric Associates, the full and entire amount of bill incurred by myself or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

There is a \$25.00 fee for missed check-ups or cancellations less than 24 hours.

Signature _____ Relationship to Patient _____ Date _____