

ABC PEDIATRICS, LTD.

CHILDREN'S INFORMATION

Last	First	Middle	Date of Birth	Sex (Circle)
_____	_____	_____	_____	M / F
_____	_____	_____	_____	M / F
_____	_____	_____	_____	M / F
_____	_____	_____	_____	M / F
_____	_____	_____	_____	M / F

PARENT'S INFORMATION

Mother's Information				Father's Information			
Last	First	Middle Init.	Date of Birth	Last	First	Middle Init.	Date of Birth
_____	_____	_____	_____	_____	_____	_____	_____
E-mail address: _____				E-mail address: _____			
Street Address: _____				Street Address: _____			
City, State, ZIP: _____				City, State, ZIP: _____			
Home Phone: (____) _____				Home Phone: (____) _____			
Cell Phone (____) _____				Cell Phone (____) _____			
Name of Employer: _____				Name of Employer: _____			
Work Address: _____				Work Address: _____			
City, State, ZIP: _____				City, State, ZIP: _____			
Work Phone: (____) _____				Work Phone: (____) _____			

RESPONSIBLE PARTY (If Other Than Above)

Name: _____ Relationship: _____
Street Address: _____
City, State, ZIP: _____ Phone: (____) _____

INSURANCE INFORMATION

Primary Insurance	Other Insurance
Name of Carrier: _____	Name of Carrier: _____
Insured Employee: _____	Insured Employee: _____
Effective Date: _____	Effective Date: _____
Deductible: per person _____ per family _____	Deductible: per person _____ per family _____
Deductible start date: _____	Deductible start date: _____
Sick Coverage: Y / N _____ % covered Copay _____	Sick Coverage: Y / N _____ % covered Copay _____
Well Coverage: Y / N _____ % covered Copay _____	Well Coverage: Y / N _____ % covered Copay _____
Immunization Coverage: Y / N	Immunization Coverage Y / N
Number of well care visits, if limited: _____	Number of well care visits, if limited: _____
Other info: _____	Other info: _____

EMERGENCY INFORMATION

Local Emergency Contact (other than parent): Phone: (____) _____
Name: _____ Relationship: _____
Address: _____

AUTHORIZATION AND ACKNOWLEDGMENT

I authorize you to give my child/children reasonable and proper medical care by today's standards. I hereby authorize the physician to release information related to any claim. I recognize and accept full responsibility for all professional services rendered and further authorize the insurance company to pay benefits directly to the physician.

Signature of Parent _____ Date _____

How were you referred to our practice? _____