Friendship Pediatrics

PATIENT LEGAL NAME: FIRST MIDDLE LAST				CHECK THE BOX OF THE PHONE NUMBER WHERE WE MAY LEAVE A MESSAGE
SEX ÿ MALE ÿ FEMALE	DATE OF BIRTH:	AGE:	SSN:	PREFERRED PHONE NUMBER :
ADDRESS: CITY STATE ZIP CODE				CELL PHONE > 16 y.o. ÿ
E-MAIL ADDRESS PREFERRED:		RACE		ETHNICITY:
PHARMACY NAME AND ADDRESS:		PHARMACY PHONE #:		NICKNAME:

PARENT #1 MOTHER/FATHER LEGAL GUARDIAN ÿ

FIRST MIDDLE LAST			HOME PHONE NUMBER: ÿ
DATE OF BIRTH:	SSN:	EMAIL ADDRESS:	WORK PHONE NUMBER: ÿ
ADDRESS: CITY STATE ZIP CODE			CELL PHONE NUMBER: ÿ

PARENT #2 MOTHER/FATHER LEGAL GUARDIANÿ

FIRST MIDDLE LAST			HOME PHONE NUMBER: ÿ
DATE OF BIRTH:	SSN:	EMAIL ADDRESS:	WORK PHONE NUMBER: ÿ
ADDRESS: CITY STATE ZIP CODE			CELL PHONE NUMBER: ÿ

PRIMARY INSURANCE PLEASE CHECK HERE IF NOT SUBSCRIBER ÿ

INSURANCE COMPANY		SUBSCRIBER(Please complete if other than the patient)		
INSURANCE COMPANY NAME		NAME OF SUBSCRIBER	TELEPHONE NUMBER	
POLICY ID NUMBER GROUP NUMBER		ADDRESS OF SUBSCRIBER		
ADDRESS		CITY STATE ZIP CODE		
CITY STATE ZIP CODE		Subscriber Relationship to patient	Date of Birth	SEX ÿM ÿF
INSURANCE COMPANY TELEPHONE NUMBER For Verification:		Employer Name and Work Number	SSN of Subscriber	

SECONDARY INSURANCE PLEASE CHECK HERE IF NOT SUBSCRIBER ÿ

Friendship Pediatrics

INSURANCE COMPANY			SUBSCRIBER(Please complete if other than the patient)		
INSURANCE COMPANY NAME			NAME OF SUBSCRIBER	TELEPHONE NUMBER	
POLICY ID NUMBER		GROUP NUMBER	ADDRESS OF SUBSCRIBER		
ADDRESS			CITY	STATE	ZIP CODE
CITY	STATE	ZIP CODE	Subscriber Relationship to patient	Date of Birth	SEX ÿM ÿF
INSURANCE COMPANY TELEPHONE NUMBER For Verification:			Employer Name and Work Number	SSN of Subscriber	

PERSON FINANCIALLY RESPONSIBLE

FIRST	MIDDLE	LAST	HOME PHONE NUMBER: ÿ
DATE OF BIRTH:	SSN:	EMAIL ADDRESS:	WORK PHONE NUMBER: ÿ
ADDRESS:	CITY	STATE ZIP CODE	CELL PHONE NUMBER: ÿ

SIBLINGS

PATIENT LEGAL NAME:	FIRST	MIDDLE	LAST	DATE OF BIRTH:
PATIENT LEGAL NAME:	FIRST	MIDDLE	LAST	DATE OF BIRTH:
PATIENT LEGAL NAME:	FIRST	MIDDLE	LAST	DATE OF BIRTH:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize **Friendship Pediatrics, P.A.** to release medical information via **mail, fax**, **electronically**, **telephone**, or **voice mail** to me or any healthcare facility in order to perform testing and obtain consultations.

I also authorize the release of necessary medical information to request reimbursement from my insurance company.

I understand that I will be responsible for any unpaid balance after my claim has been processed, if Friendship Pediatrics, P.A is a participating provider. If the practice does not participate with my insurance, I understand that I am responsible for the **full amount**.

If any unpaid balance necessitates legal action (attorney/court fees/collection agency fees) to collect this outstanding balance, I will be responsible for all these costs.

I understand that I will be responsible for charges not covered by insurance, missed appointments, school/camp forms, ETC.

Parent of Guardian Signature _____ Date_____