

PEDIATRICS IN BREVARD

Today's Date: _____

Patient's Name: _____
First Middle Last

Date of Birth: _____ Sex: _____ SS#: _____

Patient Address: _____
City State Zip

Home Phone #: (____) _____

Patient resides with (circle one): Both Parents Mother Father Guardian
If "other", list name and relationship _____

Parents current marital status (circle one) single married separated divorced widowed

Mother's Name: _____
First Middle Last

Date of Birth: _____ Social Security #: _____

Mother's Address (if different from patient): _____
City State Zip

Home Phone #: (____) _____ Cell Phone #: (____) _____

Employer's name: _____

Work Phone #: (____) _____

Father's Name: _____
First Middle Last

Date of Birth: _____ Social Security #: _____

Father's Address (if different from patient): _____
City State Zip

Home Phone #: (____) _____ Cell Phone #: (____) _____

Employer's name: _____

Work Phone #: (____) _____

Guardian's Name (if other than parents): _____
First Middle Last

Relationship to Patient: _____

Date of Birth: _____ Social Security #: _____

Guardian's Address (if different from patient): _____

Home Phone #: (____) _____ Cell Phone #: (____) _____

Employer's name: _____

Work Phone #: (____) _____

Siblings - List full name, date of birth, sex, and medical problems.

1. _____ d.o.b. _____ sex _____

Medical problems: _____

2. _____ d.o.b. _____ sex _____

Medical problems: _____

3. _____ d.o.b. _____ sex _____

Medical problems: _____

4. _____ d.o.b. _____ sex _____

Medical problems: _____

Please list two emergency contacts (other than parents):

1. _____ Relation to parents: _____

Address _____

Home Phone #: (____) _____ Work/Cell Phone #: (____) _____

2. _____ Relation to parents: _____

Address _____

Home Phone #: (____) _____ Work/Cell Phone #: (____) _____

Insurance Information

Insurance Company Name: _____

Policy Holder's Name: _____
First Middle Last

Social Security #: _____ Date of Birth: _____

Policy#: _____ Group #: _____

Pediatrics in Brevard does not file secondary insurance.

Authorization of Treatment and Insurance/Financial Agreement:

I/We hereby authorize treatment of the before named patient.

I/We hereby authorize my/our insurance benefits to be paid directly to Pediatrics in Brevard. I/We authorize the release of pertinent medical information, including disability or employment related information concerning claims to my insurance carriers, authorized agent(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expenses.

I/We, the undersigned, do hereby agree that in consideration for the services to be provided by Pediatrics in Brevard to the before named patient, assume joint and several responsibilities for the account charges, including non-covered services and those due to false information.

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____

Print Name: _____