Preferred Pediatrics

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____
Date of Birth _____ Social Security # _____ Gender _____
Physical Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Email _____

Emergency Contact Name _____ Emergency Phone _____
(Other than Parent)
Relationship to Patient _____

PARENT/GUARANTOR INFORMATION

Last Name _____ First Name _____ M.I. _____
Date of Birth _____ Social Security # _____ Marital Status _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Email _____ Cell Phone _____
Employer _____ Occupation _____ Work Phone _____

OTHER PARENT INFORMATION

Last Name _____ First Name _____ M.I. _____
Date of Birth _____ Social Security # _____ Marital Status _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Email _____ Cell Phone _____
Employer _____ Occupation _____ Work Phone _____

How did you hear about us? □ *Friend* □ *Ad* □ *Newspaper* □ *Internet* □ *Referral* □ *Other*

Pharmacy Name _____ ***Pharmacy Phone*** _____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber's Name _____
Policy ID Number _____ Relationship to Child _____
Group Number _____ Subscriber DOB _____ Effective Date _____

Secondary Insurance _____ Subscriber's Name _____
Policy ID Number _____ Relationship to Child _____
Group Number _____ Subscriber DOB _____ Effective Date _____

Patients Primary Language: □ *English* □ *Arabic* □ *Bengali* □ *French* □ *German* □*Malay* □ *Mandarin* □ *Spanish* □ *Russian* □ *Portuguese* □ *Other*
Patients Race: □ *American Indian/Alaska Native* □ *Asian* □ *Black/African American* □ *Native Hawaiian* □ *White* □ *Unknown* □ *Other*
Patients Ethnicity: □ *Hispanic/Latino* □ *Non Hispanic/Latino*

I hereby certify that the above information is correct. I authorize my insurance benefits to be paid to the provider and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information required. I further authorize service charges if the bill is not paid after 30 days. I agree to pay any/all -collection fees in the amount of 33 1/3% of my account balance or a minimum of $50.00 plus attorney fees.

Signature _____ Date _____