PREMIER PEDIATRIC CARE
PATIENT'S INFORMATION

PLEASE PRINT

LAST NAME: ________________________________ FIRST NAME: ______________________________________
DOB: ______/______/_______ SEX: M F SS #: _______________________________________
ADDRESS: ____ APT#: ________________________________
CITY: _____________________________ STATE: ________________ ZIP CODE: __________________________
HOME #: ___________________________________ CELL #: ____
PREFERRED CONTACT NUMBER: CELLPHONE HOME PHONE
FOR NOTIFICATIONS, WE MAY CONTACT YOU VIA (CHECK AS MANY AS YOU WANT):

☐ PHONE
☐ TEXT MESSAGE
☐ EMAIL EMAIL ADDRESS: ______________________________________

PHARMACY NAME: _____________________ PHARMACY ADDRESS: _________________________________
CITY: _____________________________ STATE: _________________ ZIP CODE: ________________________
PHARMACY TEL #: ____
LABORATORY NAME: ____
REFERRED BY: ____

MOTHER'S INFORMATION

LAST NAME: ________________________________ FIRST NAME: ______________________________________
DOB: ______/______/______ SS #: _________________________ OCCUPATION: _________________________
EMPLOYER: ____
WORK #: _____________________________________ CELL #: ____
DRIVER LICENSE #: ______________________________ EMAIL ADDRESS: ____________________________

FATHER'S INFORMATION

LAST NAME: ________________________________ FIRST NAME: ______________________________________
DOB: ______/______/______ SS #: _________________________ OCCUPATION: _________________________
EMPLOYER: ____
WORK #: _____________________________________ CELL #: ____
DRIVER LICENSE #: ______________________________ EMAIL ADDRESS: ____________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ____ POLICY #:__________________
ADDRESS: ____ PHONE #: _______________________
INSURED'S RELATIONSHIP TO PATIENT: SELF MOTHER FATHER OTHER
SECONDARY INSURANCE: ____ POLICY #: _________________
ADDRESS: ____ PHONE #: _______________________
INSURED'S RELATIONSHIP TO PATIENT: SELF MOTHER FATHER OTHER

INSURANCE AUTHORIZATION & ASSIGNMENT & PAYMENT RESPONSIBILITY – I hereby authorize Premier Pediatric Care to furnish information to any or all insurance carriers concerning my medical records and treatments. I authorize Premier Pediatric Care to appeal any unpaid insurance claims on my behalf. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I acknowledge and understand that I am responsible for all services rendered to me and all the charges incurred from those services. Although I requested the practitioner to bill my insurance company on my behalf, I clearly understand that I am responsible for any amount not covered by my insurance for any reason, I will also be responsible for any co-pays, co-insurance amounts, and deductibles. Any payments made directly to the patient and owing to the physician will be remitted immediately, payable to PREMIER PEDIATRIC CARE, LLC. Payment is expected when services are rendered. I am responsible for furnishing all the information requested above and responsible for furnishing any necessary insurance forms to the office prior to the office visit.

If there is a default in any one payment (no payment when due), there will be added 25% collection or attorney's fees, plus all costs, if my account goes to collection agency or collection attorney for collection or litigation.

______________________________ ______________________________ ______________________

SIGNATURE OF PARENT/GUARDIAN AUTHORIZING ALL STAEMENTS ABOVE PRINT NAME DATE

PREMIER PEDIATRIC CARE
PATIENT'S INFORMATION

PLEASE CIRCLE

RACE: WHITE
SPANISH
ASIAN
BLACK
AMERICAN INDIAN OR NATIVE
AFRICAN AMERICAN
NATIVE HAWAIIAN
OTHER PACIFIC ISLANDER

ETHNICITY: HISPANIC OR LATINO
NON-HISPANIC OR LATINO

LANGUAGE: ENGLISH
FRENCH
GERMAN
JAPANESE
MANDARIN
RUSSIAN
SPANISH
OTHER: _____________

NATIONALITY: AFRICAN AMERICAN
AMERICAN
ARABIAN
ASIAN-INDIAN
AUSTRALIAN
AUSTRIAN
BAVARIAN
BRITISH
CHINESE
EASTERN EUROPEAN
FILIPINO
FRENCH
GERMAN
HISPANIC
IRISH
ITALIAN
JAPANESE
KOREAN
MEXICAN
POLISH
PUERTO RICAN
RUSSIAN
SCOTTISH
SPANISH

PARENT/GUARDIAN SIGNATURE: _________________________________ **DATE:** ______________________