SHADY GROVE PEDIATRIC ASSOCIATES

Patient's Name ______________________________ Birthdate ______________
LAST FIRST MI
Address ______________________________ City ______________ State _____ Zip ________
Nickname ______________ Sex M F Race ______________
Home Phone ______________ **Patient's** Cell Phone ______________

Siblings

Name ______________ Birth Date ________ Sex M F
Name ______________ Birth Date ________ Sex M F
Name ______________ Birth Date ________ Sex M F
Name ______________ Birth Date ________ Sex M F

Mother/Guardian ______________
SSN ____________ DOB ____________
Address ______________
City ____________ State _____ Zip ______
Home # ____________ Cell # ____________
Work # ______________
Employer ______________
Occupation ______________

Father/Guardian ______________
SSN ____________ DOB ____________
Address ______________
City ____________ State _____ Zip ______
Home # ____________ Cell # ____________
Work # ______________
Employer ______________
Occupation ______________

Emergency Contact ______________________ Phone ______________
Relationship to Patient ______________________

INSURANCE INFORMATION

Primary Insurance

Policy Holder Name ______________
Insurance Company ______________
Ins Address ______________
____
Phone ______________
Effective Date ____________ Copay ______
ID/Contract# ______________
Group/Plan# ______________

Secondary Insurance

Policy Holder Name ______________
Insurance Company ______________
Ins Address ______________
____
Phone ______________
Effective Date ____________ Copay ______
ID/Contract# ______________
Group/Plan# ______________

_____I authorize treatment of the above patient.
_____I authorize the release of medical records necessary to process insurance claims.
_____I am responsible to pay balances for non-covered services after insurance claim is processed.
_____I authorize Shady Grove Pediatrics to receive payment of medical benefits.
_____I agree to pay for visits and/or co-pays at the time of service.
_____I authorize the release of correspondence and/or medical records to other medical providers involved in my child's care.
_____I authorize messages and/or medical information to be left on the following number ______________
Other adults who have permission to bring my child for treatment: ______________________

Signature ______________________ Date ______________

3/12/15