South Florida Pediatric Partners

PATIENT INFORMATION

Patient Name: ____
Last First Middle

Address: ____

City: ______________ State: ______________ Zip Code: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Date of Birth: ______________ SS #: ______________ Patient Sex: F M

PARENT/LEGAL GUARDIAN INFORMATION

Parent Name: ____
Last First Middle

Address: ____

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Date of Birth: ______________ SS #: ______________

Place of Employment: ____

INSURANCE INFORMATION

Insurance Co.: ____

Address: ____
City State Zip

Group # ______________________ Policy # ______________________

Group Name: ______________________ Insured's Date of Birth ______________

Patient Relationship to Subscriber: Self Spouse Child Other

A PARENT , LEGAL GUARDIAN OR ABOVE NAME ADULT MUST BE PRESENT AT TIME OF VISIT.

Please sign that you understand the above information.

______________________ ______________________
Signature Date

South Florida Pediatric Partners

Patient Name: ______________________________

Patient SS #: ______________________________

Physician Name: ______________________________

Lifetime Signature Agreement

To: ______________________________
Insurance Carrier

I authorize the release of any medical information necessary to process this claim. I also request payment of benefits to either myself or to the party who accepts assignment for the insured party.

______________________________ Responsible Party Signature

______________ Date

I authorize payment of medical benefits to South Florida Pediatric Partners for services described for my children covered under my policy. I also understand that I and/or my spouse is responsible for any unpaid balance due to South Florida Pediatric Partners.

______________________________ Responsible Party Signature

______________ Date

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MISCELLANEOUS INFORMATION

In Case of Emergency who Should we Contact:

Name: ______________________________

Home Phone #: ______________ Cell Phone # ______________

Relationship to Patient: ______________________________

Who other than the parents will bring the child to the Doctor:

Name: ______________________________ DL # ______________

Relationship to parent: ______________________________

We must a make copy of your Driver license

Please sign that you understand the above information

______________________________ ______________

Signature Date