________New Patient/Born ________Insurance________Address ________Other DATE:__________________________

Updated____________________ Updated____________________ Updated____________________

Community Pediatric Medical Group, Inc.

PATIENT INFORMATION

Please print clearly:

DATE:______________________________ **PRIMARY EMAIL ADDRESS:**____

NAMES OF ALL CHILDREN (LAST, FIRST):

____SEX:__________DOB:________________

____SEX:__________DOB:________________

____SEX:__________DOB:________________

____SEX:__________DOB:________________

____SEX:__________DOB:________________

____SEX:__________DOB:________________

HOME ADDRESS:____ **PRIMARY PHONE #:**________________

CITY:____ **STATE:**____________________ **ZIP:**________________

INSURED THROUGH: **NAME OF PARENT:**____

PARENT'S NAME:____ AGE:__________ DOB:________________

______MARRIED______SINGLE______WIDOWED______DIVORCED______SEPERATED **SS#:**________________________________

PARENT'S OCCUPATION OR POSITION AND EMPLOYER:____

CELL#____________________________ **EMAIL:**____

PARENT'S NAME:____ AGE:__________ DOB:________________

______MARRIED______SINGLE______WIDOWED______DIVORCED______SEPERATED **SS#:**________________________________

PARENT'S OCCUPATION OR POSITION AND EMPLOYER:____

CELL#____________________________ **EMAIL:**____

INSURANCE INFORMATION

_____NO INSURANCE_______PPO_____ HMO

PRIMARY INSURANCE:

INSURANCE COMPANY:____

SUBSCRIBER NAME:____ **GROUP #:**____________________

MEMBERSHIP OR SUBSCRIBER ID#:__________________________________ **DATE EFFECTIVE:**__________________

SECONDARY INSURANCE:

INSURANCE COMPANY:____

SUBSCRIBER NAME:____ **GROUP #:**____________________

MEMBERSHIP OR SUBSCRIBER ID#:__________________________________ **DATE EFFECTIVE:**__________________

PLEASE NOTE: WE MUST HAVE A COPY OF YOUR INSURANCE CARD TO BILL YOUR INSURANCE.

I hereby authorize Community Pediatrics Medical Group, Inc. to furnish any medical information to your insurance carrier. I authorize and request payment of medical benefits to Community Pediatrics Medical Group, Inc. I realize that I am financially responsible for my children's charges whether I have insurance or not.

WHO SHOULD RECEIVE BILLING STATEMENTS?____

WHAT ADDRESS?____

PARENT SIGNATURE:____ **DATE:**______________

YEAR: 2021