Community Pediatric Medical Group, Inc.

Patient Information

Please print clearly:

Date _____

Names of all children (Last, First):

_____ Sex____ DOB _____
_____ Sex____ DOB _____
_____ Sex____ DOB _____
_____ Sex____ DOB _____
_____ Sex____ DOB _____
_____ Sex____ DOB _____

Home address:_____Phone #_____
City:_____State:_____ZIP:_____

Father's Name: _____ age: ____DOB _____
SS# _____ Married__ Single__ Widowed__ Divorced__ Separated__
Father's occupation or position and employer:
_____
BusinessAddress:_____
Business phone: _____ Cell phone: _____
Driver's License #: _____ e-mail: _____

Mother's Name: _____ age: ____DOB _____
SS# _____ Married__ Single__ Widowed__ Divorced__ Separated__
Mother's occupation or position and employer:
_____
BusinessAddress:_____
Business phone: _____ Cell phone: _____
Driver's License #: _____ e-mail #: _____

Insurance Information

No Insurance ___ HMO? ___ Y ___ N Copay _____
Primary Insurance: Insured by ____ Mother ____ Father
Insurance Company: _____
Subscriber Name: _____ Group #: _____
Membership or subscriber #: _____ Date effective: _____

Secondary Insurance:
Insurance Company: _____
Subscriber Name: _____ Group #: _____
Membership or subscriber #: _____ Date effective: _____

Please note: We must have a copy of your insurance card to bill your insurance

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

Parent Signature _____ Date: _____