DUNDALK PEDIATRIC ASSOCIATES, P.A.

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PATIENT'S INFORMATION

PATIENT NAME: First Middle Last	SOCIAL SEC #	M ☐ F ☐	DATE OF BIRTH	AGE

HOME ADDRESS	APT NO.	CITY

STATE	ZIP	HOME PHONE	ALLERGIES

HAVE ANY OF YOUR CHILDREN BEEN SEEN IN THIS OFFICE?
☐ Yes ☐ No LIST THEIR NAMES

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
NAME	DATE OF BIRTH	NAME	DATE OF BIRTH

FATHER'S INFORMATION

FIRST	MI	LAST	SOCIAL SECURITY NUMBER

HOME ADDRESS	APT NO.	CITY	STATE	ZIP

EMPLOYER	ADDRESS

HOME PHONE	CELL OR ALTERNATE PHONE	WORK PHONE

MOTHER'S INFORMATION

FIRST	MI	LAST	SOCIAL SECURITY NUMBER

HOME ADDRESS	APT NO.	CITY	STATE	ZIP

EMPLOYER	ADDRESS

HOME PHONE	CELL OR ALTERNATE PHONE	WORK PHONE

BILLING INFORMATION

FINANCIALLY RESPONSIBLE PERSON ☐ Patient ☐ Father ☐ Mother ☐ Other________	NAME IF DIFFERENT FROM MOTHER OR FATHER	HOME PHONE

FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (IF DIFFERENT FROM PATIENT)

FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER	EMPLOYER ADDRESS	WORK PHONE

INSURANCE INFORMATION

POLICY HOLDER ☐ Patient ☐ Father ☐ Mother ☐ Other	PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER'S NAME AND	DATE OF BIRTH / /

INSURANCE CO. ADDRESS	ID/POLICY NO.	GROUP NO.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Co-Payments Due at Check-In

THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED

Balances 60 days old will be turned over to a Collection Agency.

I,____________________, hereby authorize Dundalk Pediatric Associates to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to the physician in charge of my care. I authorize release of the necessary medical information.

____
Signature of Subscriber or Beneficiary

______/______/______
Date