Patient Information

Child's Name ________________________ Home Phone ____________________

Address ____________________ City ________________ State ______ Zip _______

County of Residence ________ Date of Birth ___ /___ /___ Sex M F Place of Birth _______ (City)

School or Day Care ________________________________ Phone ________________

Child's SS#______________

Mother's Name ________ (First) ________ (Maiden) ________ (Last) Date of Birth ___/___/___ SS# ________

Address (if different) ______________________ Email: ________________________

Employer ____________________ Work Phone ____________ Cell No. ____________

Father's Name ________________________ Date of Birth ___/___/___ SS# ________

Address (if different) ______________________ Email: ________________________

Employer ____________________ Work Phone ____________ Cell No. ____________

Emergency Contact (other than parents)________________ Phone ________________

____ Phone ________________

Closest Relative ____________ Phone ____________ Second No. ______________

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Insurance __________________________ Subscriber's Name ________________

Group # __________________ ID # ________________ Date of Birth ____________

Secondary Insurance ____________________ Subscriber's Name ________________

Group # __________________ ID # ________________ Date of Birth ____________

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Names of other family members who are patients of ours ____________________________

________________________ Provider you prefer for your child ________________

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

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I hereby consent to the rendering of medical care by Burlington Pediatrics physicians and staff as it may in their professional judgment be necessary. I authorize the release of protected health information to any consultant for the purpose of continuing care. I authorize the release of information acquired in the course of my child's examination for the purpose of filing insurance claims. I assign insurance payment directly to Burlington Pediatrics. I understand that I am ultimately responsible for payment of charges, whether or not they are covered by insurance. This authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be as valid as the original.

Date ______________ Signature ______________________________

Relationship to Patient ________________________