Preferred Pediatrics

PATIENT INFORMATION

Last Name ____________ First Name ____________ M.I. ____________
Date of Birth ____________ Social Security # ____________ Gender ____________
Physical Address ____________ City ____________ State ____________ Zip ____________
Home Phone Number ____________ Email ____________
Emergency Contact Name ____________ Emergency Phone ____________
(Other than Parent)
Relationship to Patient ____________

PARENT/GUARANTOR INFORMATION

Father's Last Name ____________ First Name ____________ M.I. ____________
Date of Birth ____________ Social Security # ____________ Marital Status ____________
Mailing Address ____________ City ____________ State ____________ Zip ____________
Home Phone Number ____________ Email ____________ Father's Cell Phone ____________
Father's Employer ____________ Occupation ____________ Work Phone ____________

Mother's Last Name ____________ First Name ____________ M.I. ____________
Date of Birth ____________ Social Security # ____________ Marital Status ____________
Mailing Address ____________ City ____________ State ____________ Zip ____________
Home Phone Number ____________ Email ____________ Mother's Cell Phone ____________
Mother's Employer ____________ Occupation ____________ Work Phone ____________

How did you hear about us? ☐ *Friend* ☐ *Ad* ☐ *Newspaper* ☐ *Internet* ☐ *Referral* ☐ *Other*

Pharmacy Name ____________ ***Pharmacy Phone*** ____________

INSURANCE INFORMATION

Primary Insurance ____________ Subscriber's Name ____________
Policy ID Number ____________ Relationship to Child ____________
Group Number ____________ Subscriber DOB ____________ Effective Date ____________

Secondary Insurance ____________ Subscriber's Name ____________
Policy ID Number ____________ Relationship to Child ____________
Group Number ____________ Subscriber DOB ____________ Effective Date ____________

Patients Primary Language: ☐ *English* ☐ *Arabic* ☐ *Bengali* ☐ *French* ☐ *German* ☐*Malay* ☐ *Mandarin* ☐ *Spanish* ☐ *Russian* ☐ *Portuguese* ☐ *Other*
Patients Race: ☐ *American Indian/Alaska Native* ☐ *Asian* ☐ *Black/African American* ☐ *Native Hawaiian* ☐ *White* ☐ *Unknown* ☐ *Other*
Patients Ethnicity: ☐ *Hispanic/Latino* ☐ *Non Hispanic/Latino*

I hereby certify that the above information is correct. I authorize my insurance benefits to be paid to the provider and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information required. I further authorize service charges if the bill is not paid after 30 days. I agree to pay any/all -collection fees in the amount of 33% of my account balance or a minimum of $50.00

Signature ____________ Date ____________