PEDIATRIC associates

Date _____

3516 12th Ave NE * Olympia, WA 98506 * 360-456-1600

PATIENTS INFORMATION:

First name MI Last name Date of birth M/F

Street/PO Box City State Zip Home phone number

Other Children (seen as patients):

First Name MI Last name Date of birth M/F

First Name MI Last name Date of birth M/F

First Name MI Last name Date of birth M/F

First Name MI Last name Date of birth M/F

Parent or Guardian information: *(Living in same household as patient)*

Relationship to patient: _____

First Name MI Last Name Date of Birth SS#

Street/PO Box City State Zip

Home number Work number Cell number

IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING? ☐ Yes ☐ No

Parent or Guardian information (other contact):

Relationship to patient: _____

_____

First Name MI Last Name Date of Birth SS#

_____

Street/PO Box City State Zip

_____

Home number Work number Cell number

IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING? ☐ Yes ☐ No

INSURANCE INFORMATION:

Primary Insurance:

_____

Name of Plan Subscriber ID# Group# Effective date

_____

Subscribers name Date of Birth Employer

Subscriber's relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Other (explain):_____

Secondary Insurance:

_____

Name of Plan Subscriber ID# Group# Effective date

_____

Subscribers name Date of Birth Employer

Subscriber's relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Other (explain):_____

Emergency Contact Information: (*Relative/friend outside of the household)*

_____

First name Last name Contact number Relationship to patient

Contact information will remain in place until changed in writing by you

Authorization for treatment of a minor:

I, _____, the parent/legal guardian of _____, hereby authorize the physicians of Pediatric Associates to provide medical care to the above name minor child.

_____

Signature Date Relationship to patient

Financial responsibility, Release of Information and Assignment of Benefits:

I hereby authorize release of information necessary to file a claim with my insurance company, and assign benefits otherwise payable to me to the doctor or group indicates on the claim. I understand I am financially responsible for any balance not covered by my insurance company. A copy of this signature if just as valid as the original.

_____

Signature Date Relationship to patient