MONTGOMERY PEDIATRICS

PARENT INFORMATION Please Print

Father's Name_____ Mother's Name_____

Address_____ Address (If different)_____

City_____State_____Zip _____-_____ City_____State_____Zip _____-_____

Home Phone_____Work Phone_____ Home Phone_____Work Phone_____

Father's Cell Phone_____ Mother's Cell Phone _____

Person responsible for bills: _____ PREFERRED NUMBER FOR REMINDER CALLS:_____

Email Address: _____

PATIENT INFORMATION **Oldest Child** **Second Child**

Full Name_____ Full Name_____

Nickname/"Goes By" _____ Nickname/"Goes By" _____

Date of Birth_____Age_____ Sex (Circle) M F Date of Birth_____ Age _____ Sex M F

SSN #_____Doctor: CL SL ER SD AH SSN#_____Doctor: CL SL ER SD AH

Third Child **Fourth Child**

Full Name_____ Full Name_____

Nickname/"Goes By" _____ Nickname/"Goes By" _____

Date of Birth_____Age_____ Sex M F Date of Birth_____Age _____ Sex M F

SSN #_____Doctor: CL SL ER SD AH SSN#_____Doctor: CL SL ER SD AH

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance_____

Ins. Address_____ Ins. Address_____

Policy #_____Grp #_____ Policy # _____Grp #_____

Subscriber_____Copay $_____ Subscriber _____Copay $ _____

Birthdate_____SSN# _____ Sex M F Birthdate_____SSN#_____Sex M F

Employer_____ Employer _____ _____

Occupation _____Policy Eff. Date_____ Occupation _____Policy Eff. Date _____

AUTHORIZED PERSON'S SIGNATURE:

I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to **MONTGOMERY PEDIATRICS**, **INC.** A photocopy of this assignment is to be considered as valid as an original. I authorize **MONTGOMERY PEDIATRICS, INC.** to release information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance.

In the event that the parent(s) or legal guardian(s) are unable to accompany the child during an office visit, I hereby authorize the physicians of **MONTGOMERY PEDIATRICS, INC**. to evaluate and treat any and all conditions that require medical care, be they immediate or scheduled health maintenance care.

I will accept mail and reminder phone calls from **MONTGOMERY PEDIATRICS, INC.** I authorize **MONTGOMERY PEDIATRICS, INC.** to release necessary information requested for immunizations, school forms, medication authorizations at school, and forms for day care, sports, camp, scouts and work permits, etc. I have been shown a copy of the Privacy Policies for **MONTGOMERY PEDIATRICS, INC.**

Signed _____

Date_____