Birth & Beyond Pediatrics, P.C.

Patient Identification Form

(Please Print)

Patient Name _____ Referred By: _____

Patient Address:_____ Phone #:_____
Street City State Zip

DOB: _____ Sex: ____ SS#: _____ Dr.:_____
Primary physician your child will see

Siblings: _____

E-Mail: _____ Recipient/Relation: _____

Pharmacy: _____ Pharm. Location: _____

Guarantor's Name _____ SS# _____ Birthdate _____

Relation to patient: Father Mother Other: _____

Address: _____ Hm Phone _____ Cell _____
Street City State Zip

Spouse's Name _____ SS# _____ Birthdate _____

Relation to patient: Father Mother Other:_____

Address: _____ Hm Phone _____ Cell _____
Street City State Zip

Guarantor's Employer _____ Employer/phone #_____

Spouse's Employer _____ Employer/phone # _____

Contact outside of home _____

Relation _____ Phone Number _____

Insurance Company Name _____

Group No. _____ Plan No. _____ ID # _____

Effective Date _____ Subscriber _____

Subscriber DOB: _____ Claim Address: _____

Secondary Insurance Company _____

Group No. _____ Plan _____ ID # _____

Effective Date _____ Subscriber _____

Subscriber DOB: _____ Claim Address: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read and sign):

I hereby authorize Birth & Beyond Pediatrics, P.C. to furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for medical services rendered to my child. I understand that I am ultimately responsible for any amounts not covered by insurance. I further permit a copy of this authorization to be used in place of original.

_____

Signature of Parent/Legal Guardian Date