Date of First Visit ____________

Birmingham Pediatric Associates

Account Number ____________

Personal Data *(Please print.)*

Child's Full Name ____________ *Last* *First* *Middle*

Nickname or Call Name ____________

Date of Birth ____________ *Mo.* *Day* *Yr.*

Sex: ☐ Male ☐ Female

Place of Birth ____________ *Hospital* *City* *State*

Address ____________ *Street* *City* *State* *Zip Code*

Phone # ____________ *Home*

Insurance Data

Subscriber/Insured ____________

Insurance Co. ____________

Contract or I.D. Number ____________

Group/Co. Insured ____________

Effective Date ____________

Date of Birth ____________

Family Data

	Mother	Father
Name		
Date of Birth		
Address		
Drivers License #		
Employer/Position Held		
Cell Phone #		
Work Phone #		
Home Phone #		
Social Security Number		

Friend or Family Member for Emergencies ____________ Telephone ____________

Referred by ____________

Please list all children in family that are less than 18 years old.

#	Name	Sex M	Sex F	Birthday Mo.	Birthday Day	Birthday Yr.	Patient's Social Security No.
1							
2							
3							
4							
5							
6							

Guarantee: *In consideration of the services provided or to be provided, I, the undersigned, agree to pay the physician(s) for the service rendered to above said patient. Failing to do so, I hereby waive all claims or rights of exemption and agree to pay a reasonable attorney's fee for the collection of the account if assigned to an attorney for collection.*

Signed ____________

As the parent or legal guardian. I the undersigned authorize the physician to render medical services to the above patient, and to release medical and/or any other information necessary to the third party payer, at their request, in order to assist in processing any medical claim.

Signature ____________ Date ____________

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