Date of First Visit _____

Birmingham Pediatric Associates

Account Number _____

Personal Data *(Please print.)*

Child's Full Name _____ Nickname or Call Name _____
Last *First* *Middle*

Date of Birth _____ Sex: ❑ Male ❑ Female Place of Birth _____
Mo. *Day* *Yr.* *Hospital* *City* *State*

Insurance Data - If card not present

Subscriber/Insured _____ Insurance Co. _____

Contract or I.D. Number _____ Group/Co. Insured _____

Effective Date _____

Family Data

	Mother	Father
Name		
Date of Birth		
Address		
City, State and Zip		
Email		
Cell Phone #		
Work Phone #		
Home Phone #		
Social Security Number		

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

#	Name	Sex M	Sex F	Birthday Mo.	Day	Yr.	Biologically related? check if yes Mother	Father
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 and/or collection 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 _____