Date of First Visit _____

Birmingham Pediatric Associates
Please Print Clearly

Account Number _____

#	Please list full name of all children in family that are less than 18 years old	birthday			sex		Child resides with… (check all that apply) *if other, please specify below			Biological parent? check if yes		If less than one year old: Place of birth (city, state, hospital)
		Mo.	Day	Yr.	m	f	Parent 1	Parent 2	other	Parent 1	Parent 2	
1										◎	◎	
2										◎	◎	
3										◎	◎	
4										◎	◎	
5										◎	◎	
6										◎	◎	

	Parent 1		Parent 2	
circle one →	Mother	Father	Mother	Father
Name				
Date of Birth				
Street Address				
City, State, and Zip				
Primary Phone #				
Work Phone #				
Cell Phone #				
Email Address				
Social Security Number				

*if other was selected above, please specify:
Name: _____ DOB: _____
Street Address: _____
Primary Phone #: _____

Insurance Data – if card is not present
Subscriber/Insured _____ Insurance Co. _____
Contract or I.D. number _____ Group/Co. Insured _____
Effective Date _____ _____

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.*

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: _____