**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 | | | | |
| Occupation | | | | |

*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: _____