Welcome to Caring Pediatrics

We strive to make each of your child's visits a pleasant experience.
Please fill out this form completely print and clear

Today's Date________________________

Child's Name: ____**Male**____ **Female**______ **D.O.B.** ___________

Home Address: ____

City: __________________________________ **State**: ____________________________ **Zip Code**: ______________________

Dad's Name____________________________________ **Dad's D.O.B.** ____________ **Dad's S.S. #** _______________________

Dad's Home/Cell# ____**Email:** ____________________________________

Dad's Employer: ____ **Dad's Work #** _________________________________

Mom's Name____________________________________ **Mom's D.O.B**. __________ **Mom's S.S. #** ______________________

Mom's Home/Cell# ____**Email:** _____________________________________

M**om's Employer**: ____ **Mom's Work#** __________________________________

RESPONSIBLE PARTY'S HOME ADDRESS {IF DIFFERENT} ____

Insurance Information

Primary Insurance Name: ____

Policy Holder: _____________________________________**D.O.B**. ______________ **S.S. #**___________________________

Insurance ID# _________________________________ **Group #**_______________**Copay: $** _______ **Deductible: $**___________

Secondary Insurance Name: ____

Policy Holder: ____________________________________**D.O.B.** ______________**S.S. #** _____________________________

Insurance ID# _________________________________ **Group #**_______________**Copay: $** _______ **Deductible: $**___________

Financial Arrangements

Your Insurance Company requires that all copays be paid at the time of service. All **Unpaid co-pays** will be assessed a $10 handling fee each billing cycle. All forms carry a $5.00 fee for one form, $2 for each additional form ready in two days and same day form $10. Referral for any specialist called on same day of service $25 fee. For No Shows the is fee $25.00

Authorization and Release

I authorize the doctor to release any information including the diagnosis and records of any treatment or examination provided my child to my insurance company and/ or other healthcare providers.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ ______________________________

Signature of Patient or Parent, if minor **Date**