MACARTHUR PEDIATRICS

NEW PATIENT PAPERWORK

Child's Name _____ _____**Sex** _____ **DOB** _____
Sibling Name _____ _____Sex _____ DOB _____
Sibling Name _____ _____Sex _____ DOB _____

Address Where Child/Children Reside

_____
City_____ State_____ Zip Code_____
Pharmacy _____ Phone_____ Fax _____

Father's Name _____DOB_____
Address if Different than Child _____
Social Security # _____ DL # _____
Hm Phone _____ Cell Phone _____
Employer Name & Address _____
Wk Ph _____Email Address _____
Mother's Name _____DOB_____
Address if Different than Child _____
Social Security # _____ DL # _____
Hm Phone _____ Cell Phone _____
Employer Name & Address _____
Wk Ph _____Email Address _____

Please Provide the Following Information of the Responsible Party
Name & Address _____ Relationship to Child _____
_____Phone # _____
Social Security # _____ DL # _____
Employer Name & Address _____ Wk # _____

Emergency Contact _____ Phone # _____
Address _____City _____State _____Zip_____

Name Of Insurance Company _____HMO POS EPO ASO PPO
Name of Insured _____DOB_____ SSN _____
Policy # _____Group # _____ Phone # _____
Claims Mailing Address _____
Secondary Insurance Company _____HMO POS EPO ASO PPO
Name of Insured _____DOB_____ SSN _____
Policy # _____Group # _____ Phone # _____
Claims Mailing Address _____

Referred By _____

Assignment of Benefits – *I hereby authorize the release of any medical information necessary to process an insurance claim and assign payment to be made directly to MACARTHUR PEDIATRICS. A photo copy of this agreement is to be considered as valid as the original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE STATUS OF MY INSURANCE CLAIMS AND IN THE EVENT THAT ONE OF MACARTHUR PEDIATRICS PHYSICIANS IS NOT DECLARED YOUR PRIMARY CARE PHYSICIAN, I AM AWARE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED.*

Patient/Guardian Signature _____ **Date** _____