# CENTRAL FLORIDA PEDIATRICS

## *PATIENT INFORMATION*

| ACCOUNT NUMBER | |
|---|---|
| DATE | OFFICE |
| | |

| CHILD'S NAME-LAST | FIRST | MIDDLE | SEX ☐ Male ☐ Female | DATE OF BIRTH |
|---|---|---|---|---|
| PATIENT SOC. SEC. NO. | *Child Lives With:* ☐ Both Parents ☐ Mother ☐ Father ☐ Visiting, (Lives Elsewhere) ☐ Other (Specify): | | *Person To Bill:* ☐ Mother ☐ Father ☐ Other (Specify): | |

| SIBLING'S NAME-LAST | FIRST | MIDDLE | SEX ☐ Male ☐ Female | DATE OF BIRTH |
|---|---|---|---|---|
| PATIENT SOC. SEC. NO. | *Child Lives With:* ☐ Both Parents ☐ Mother ☐ Father ☐ Visiting, (Lives Elsewhere) ☐ Other (Specify): | | *Person To Bill:* ☐ Mother ☐ Father ☐ Other (Specify): | |

## FAMILY INFORMATION

| FATHER'S NAME-LAST | FIRST | MIDDLE | EMPLOYER |
|---|---|---|---|
| HOME ADDRESS | CITY | STATE | ZIP CODE |
| HOME PHONE | WORK PHONE | DATE OF BIRTH | SOC. SEC. NO. |

| MOTHER'S NAME-LAST | FIRST | MIDDLE | EMPLOYER |
|---|---|---|---|
| HOME ADDRESS | CITY | STATE | ZIP CODE |
| HOME PHONE | WORK PHONE | DATE OF BIRTH | SOC. SEC. NO. |

*Who may we thank for referring you:*

## INSURANCE INFORMATION

*Insurance Company Name:*

| SUBSCRIBER'S NAME | POLICY NUMBER | GROUP NAME |
|---|---|---|
| | | |

## OTHER INFORMATION

| *Name of Relative, Friend or Neighbor who can be reached in case of Emergency:* | | PHONE |
|---|---|---|
| *Method of Payment:* ☐ Check ☐ Cash ☐ Credit Card (Visa, MC, Discover) | DRIVER'S LICENSE NO. | **A COPY OF YOUR DRIVER'S LICENSE AND INSURANCE CARD IS REQUIRED** |
| *Name of Person Bringing in Child:* | | RELATIONSHIP |

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advanced.

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize all Doctors of Central Florida Pediatrics to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the Physician(s) all payments for any amount not covered by insurance.

Signature _____ Date _____