Plymouth Pediatric ASSOCIATES

Please review all of the following information and fill in as much information as you can.

PATIENT INFORMATION:

NAME: _____ SEX: M / F

Date of Birth: _____ MAILING ADDRESS:_____
_____
_____

Best 2 Phone numbers to reach patient/Guardian: _____home/ cell / other
_____ home/ cell / other

Patient Cell #: _____

Ethnicity- Please circle one: Hispanic/Latino Non-Hispanic/Latino Declined Race: _____
Language preference: _____

Email: _____ Are you interested in the patient portal? Yes / No
Parent/Guardian #1 Name: _____ Address:_____
Cell #: _____ _____

Parent/Guardian# 2 Name: _____Address :_____
Cell #: _____ _____

INSURANCE INFO IF CARD NOT SUPPLIED:

1.) Insurance Name: _____ Subscriber: _____
Policy Number: _____ Group #: _____
Patient's relationship to subscriber: _____ Group name: _____

2.) Secondary Insurance: _____ Subscriber: _____
Policy Number: _____ Group #: _____
Patient's relationship to subscriber: _____ Group name: _____

I consent to medical treatment by Plymouth Pediatric Associates, LLC. and authorize the release of information necessary to other attending physicians and for the processing of insurance claims, so that benefits may be paid on my behalf for services provided to me and/or my child. I further authorize payment of these benefits to Plymouth Pediatric Associates, LLC.

_____ _____
Signature of Guardian/ Patient Date