UPDATE INFORMATION

PATIENT'S INFORMATION

FULL NAME M F DOB SS#

FULL NAME M F DOB SS#

STREET ADDRESS:

CITY: STATE: ZIP CODE:

HOME PHONE NO.: PREFERRED PHARMACY

RACE: PRIMARY LANGUAGE SPOKEN: CHILD'S ETHNICITY: ___HISPANIC ___NON HISPANIC

FAMILY EMAIL ADDRESS:

PARENT'S INFORMATION

MOTHER'S NAME: DOB: / / SS#.:

EMPLOYER: WORK NO: DO YOU WISH TO RECEIVE TEXT MESSAGE REMINDERS? _____

CELL PHONE NUMBER: WHO IS YOUR CELL PHONE WITH?

FATHER'S NAME: DOB: / / SS#.:

EMPLOYER: WORK NO: DO YOU WISH TO RECEIVE TEXT MESSAGE REMINDERS? _____

CELL PHONE NUMBER: WHO IS YOUR CELL PHONE WITH?

CHILD LIVES WITH (CIRCLE ONE) MOTHER FATHER BOTH OTHER

GUARDIAN'S NAME: DOB: / / SS#.:

EMPLOYER: WORK NO:

CELL PHONE NUMBER:

EMERGENCY CONTACT (OTHER THAN PARENTS):

ADDRESS: PHONE NO.

BILLING AND INSURANCE INFORMATION

ALL CO-PAYS AND PAST DUE BALANCES ARE DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

PRIMARY INSURANCE (WE WILL NEED A COPY OF THE CARD)

NAME OF INS. CO.: _____

CONTRACT #:_____GROUP #_____

POLICY HOLDERS NAME _____ DOB:_____

POLICY HOLDERS NAME: EMPLOYER:_____ RELATIONSHIP TO PT: _____

SECONDARY INSURANCE (WE WILL NEED A COPY OF THE CARD)

NAME OF INS. CO.: _____

CONTRACT #:_____GROUP #_____

POLICY HOLDERS NAME _____ DOB:_____

POLICY HOLDERS NAME: EMPLOYER:_____ RELATIONSHIP TO PT: _____

By listing numbers on this form, I give Pediatric Associates of Auburn, and/or our agents permission to contact you by telephone at any telephone number associated with your account, including wireless telephone number, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice message and/or use of automatic dialing device, as applicable.

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I UNDERSTAND THAT PAYMENT OF ALL MEDICAL CARE IS DUE AT THE TIME OF SERVICE. THE PARENT AND/OR LEGAL GUARDIAN WHO SIGNS THIS FORM IS RESPONSIBLE FOR ANY AND ALL CO PAYS, DEDUCTIBLES, CO- INSURANCE, AND/OR UNPAID BALANCES NOT COVERED BY INSURANCE, REGARDLESS OF MARTIAL STATUS. I, THE UNDERSIGNED, ACCEPT THE FEE CHARGED AS A LEGAL AND LAWFUL DEBT AND AGREE TO PAY SAID FEE, INCLUDING ANY/ALL COLLECTION AGENCY FEES, (33.33%), ATTORNEY FEES AND OR COURT COSTS, IF SUCH BE NECESSARY. I HEREBY GRANT PERMISSION TO PEDIATRIC ASSOCIATES OF AUBURN) TO RELEASE AND OBTAIN ANY PERTINENT INFORMATION NEEDED FOR TREATMENT AND/OR PAYMENT; I ALSO AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC ASSOCIATES OF AUBURN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Date: _____ Signature of Parent or Guardian _____