



Pediatrics

Patient Information

Patient's Name: _____ (_____)

 First Middle Last Preferred

Date of Birth: _____ Sex: M F SS# _____ - _____ - _____ Race: _____

Person patient lives with: _____ Relationship: _____

Legal Guardian: _____ Relationship: _____

Primary Caregiver: _____ Relationship: _____

Parent's (or Guardian's) Information:

Full Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email: _____

Insurance Information

Company: _____ Insured Name: _____

Group Name: _____ Relationship to Patient: _____

Employer: _____ DOB: _____ Sex: M F

Guarantor (person responsible for bill) Information

Full Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

SS#: _____ - _____ - _____ Date of Birth: _____ Email: _____

Employer: _____

Are other siblings under our care? Y N

Name: _____ DOB: _____

Name: _____ DOB: _____

Emergency Contact: Other than Custodial Parent

Name: _____

Address: _____ Relationship: _____

Preferred Pharmacy: _____ Phone: _____

Consent: I consent to medical treatment necessary for the above patient.

Signature Relationship Date

All professional services rendered are the financial responsibility of the patient. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims. *By signing below, I hereby consent to my insurance carrier releasing all necessary information to Affinity Health Group, LLC regarding the status of my claims. Further, I hereby authorize Affinity Health Group, LLC to furnish information to my insurance carrier concerning my medical history, illness and treatments. Further, I authorize my insurance carrier to pay directly to Affinity Health Group, LLC all benefits to which I and/or my dependents may be eligible for the provision of healthcare services.

*****I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS ABOVE*****

SIGNATURE: _____ **DATE:** _____