Union Pediatrics, PSC
Patient Information Form

(Please list all patients who will be seen in this office. Use reverse side to list additional names.)

PATIENT(S) INFORMATION Name:Last First MI	School	M/F	DOB Mo/Day/Year	Social Security No.

Street Address:	City/State/Zip:
Home Phone:	Email:

PARENT/GUARDIAN 1:	PARENT/GUARDIAN 2:
Last Name First MI	Last Name First MI
Street Address (if different)	Street Address (if different)
City State Zip	City State Zip
Home Phone Work Phone	Home Phone Work Phone
Cell Phone DOB	Cell Phone DOB

Insurance Information [ ] Primary [ ] Secondary	Insurance Information [ ] Primary [ ] Secondary
Insurance Company Name	Insurance Company Name
Claim Mailing Address	Claim Mailing Address
City State Zip	City State Zip
Phone No	Phone No
Policy/ID No.	Policy/ID No.
Employer Name	Employer Name

Emergency Contact	Relationship	Phone Number

Pharmacy Name	Pharmacy Address	Pharmacy Phone Number

ASSIGNMENT OF BENEFITS

I hereby authorize release of information necessary to file a claim with my insurance company and assign payment of all medical benefits to **Union Pediatrics, PSC**. In addition to the foregoing, I authorize the release of my child/dependent's medical information by or between any of my treating physicians and my insurer, HMO, health benefits payer, or any other entity (including but not limited to third party administrators, management companies and provider networks) included in the administration of my child/dependent's health benefits.

Signature _____ Date _____