UNION PEDIATRICS, PSC

Patient Information Form

(Please list all patients who will be seen in this office – use reverse side to list more names)

CHILD(REN)'S INFORMATION Last Name First MI School	M/F	DOB (Mo/Day/Yr)	Social Security No. (if ADD)

Street Address	City/State/ZipCode
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 Is this primary____or secondary____		INSURANCE INFORMATION Is this primary____or secondary____	
Insurance Company Name		Insurance Company Name	
Claim Mailing Address		Claim Mailing Address	
City State Zip		City State Zip	
Phone No	Effective date	Phone No	Effective date
Policy/ID No	Group No	Policy ID No	Group No
Employer Name		Employer Name	

OTHER EMERGENCY CONTACT (list more than one if necessary)		
Name	Relationship	Phone

Pharmacy Name	Pharmacy Address
Pharmacy Phone	

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_____