McKinney Pediatrics

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PATIENT INFORMATION

Patient's Name: _____ Male ☐ Female ☐
First *Middle* *Last*

Date of Birth: ____ | ____ | ____ Home Phone: _____
Month *Day* *Year* Alt Phone: _____

Patient's Address: _____
Number *Street* *Apartment#*

_____
City *State* *Zip Code*

Name of Siblings: _____

Emergency Contact Name: _____ Phone: _____

RESPONSIBLE PARTY CONTACT INFORMATION

Mother's Information Patient lives with mother ☐

Name: _____ Date of Birth: _____
E-mail address: _____ Driver's License #: _____
Home Phone: _____ Social Security #: _____
Cell Phone: _____ Work Phone: _____

Father's Information Patient lives with father ☐

Name: _____ Date of Birth: _____
E-mail address: _____ Driver's License #: _____
Home Phone: _____ Social Security #: _____
Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Name of person that provides the insurance: _____
Relationship to patient: _____ Employer: _____
Name of Insurance Company: _____ Employer Phone: _____
Patient's Insurance ID #: _____ **Insurance Group #**: _____
Insured's Date of Birth: _____ Effective Date: _____
Do you also have Medicaid: Yes No

How did you find us? | *Friend* | *Driving by* | *Advertisement* | *Your Insurance* | *Other:*

Signature below indicates financial responsibility for all charges incurred on this account for any portion of your account not paid in full. This is a legally binding agreement for financial responsibility for collection fees, late charges, and any legal fees for nonpayment of the account. This is also a legally binding agreement for McKinney Pediatrics, P.A. to treat and care for your child, unless otherwise noted. Please note that payment is due at time of service unless prior arrangements have been made and agreed to.

THE PERSON WHO BRINGS THE DEPENDENT CHILD TO THIS OFFICE IS RESPONSIBLE FOR THE BILL.

Responsible Party Signature: _____
Responsible Party Printed: _____ Date: _____