Port Orange Pediatrics, PA

1728 Dunlawton Ave. • Suite #1
Port Orange, FL 32127
386-322-5390

Names of Children **(Please Print)** **Date**_____

Last Name	First Name	Middle	Sex M/F	Date of Birth	Social Security Number

(Please list additional children on the back)

Patient Address _____ **City**_____ **ST**_____ **Zip**_____

Home Phone Number (_____)_____

Emergency Contact Other Than Parents _____

Relationship of Emergency Contact _____ **Phone Number** (_____)_____

Name of Additional Caretaker _____ **Relationship** _____ **Phone Number** (_____)_____
(Example: stepparent, grandparent, babysitter, etc.)

Responsible Party Information

Father/Legal Guardian			Mother/Legal Guardian		
Name			Name		
Birthdate	SSN		Birthdate	SSN	
Address			Address		
City	ST	Zip	City	ST	Zip
Home Phone ( )			Home Phone ( )		
Cell Phone ( )			Cell Phone ( )		
Employed By			Employed By		
Occupation			Occupation		
Work Phone ( )			Work Phone ( )		
Email Address			Email Address		

Insurance Information

(Please furnish us with a copy of your insurance card.)

NOTE: Patients who carry health insurance should remember that payment for our services is the responsibility of the insured, and patients are expected to pay their co-pay at the time of service. Any balance not covered by insurance is due and payable upon receipt of billing statement.

Primary Insurance		**Secondary Insurance**	
Name of Insured		**Name of Insured**	
Relationship to Patient		**Relationship to Patient**	
ID #	**Group #**	**ID #**	**Group #**

ACKNOWLEDGEMENT OF RECEIPT: I hereby acknowledge that I have received the Notice of Privacy Practices of Port Orange Pediatrics, PA. I understand this notice contains information regarding how Port Orange Pediatrics, PA uses my medical information.

ASSIGNMENT AND RELEASE: I hereby authorize Port Orange Pediatrics, PA, to treat and to furnish information to insurance carriers concerning treatment, and I hereby assign to the provider all insurance benefits otherwise payable to me for these services. I understand that I am financially responsible for all charges not covered by my insurance. I also authorize Port Orange Pediatrics, PA to make reasonable disclosures of my children's Personal Health Information to parents, schools, doctors, and others involved in their care, unless otherwise specified.

Parent's Signature _____ Date_____