

**All Better Pediatrics, PC  
2011 Patient Information Sheet**

New Patient

Established Patient Update

Referred by: \_\_\_\_\_

**Children/Sibling Information**

Patient Name (Line 1)	Nickname	Gender	DOB	SSN
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

**Billing Address**

**Father/Legal Guardian**

Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_  
 SSN \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 E-Mail \_\_\_\_\_

Father's Employer \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
 Phone \_\_\_\_\_

**Primary Insurance Information**

Insurance Carrier \_\_\_\_\_  
 Claims Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_  
 Policy Holders DOB \_\_\_\_\_  
 Policy Holders ID# \_\_\_\_\_  
 Group #/Name \_\_\_\_\_  
 Effective Date of Insurance \_\_\_\_\_

**Billing Address**

**Mother/Legal Guardian**

Name \_\_\_\_\_  
 Birthdate \_\_\_\_\_  
 SSN \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 E-Mail \_\_\_\_\_

Mother's Employer \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_  
 E-Mail \_\_\_\_\_

**Secondary Insurance Information**

Insurance Carrier \_\_\_\_\_  
 Claims Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_  
 Policy Holders DOB \_\_\_\_\_  
 Policy Holders ID# \_\_\_\_\_  
 Group #/Name \_\_\_\_\_  
 Effective Date of Insurance \_\_\_\_\_

INSURANCE: I hereby authorize All Better Pediatrics, PC to furnish information to insurance carriers concerning my child's illness and treatments, and I hereby assign to the physicians all payments for medical services rendered to my child. I understand that I am responsible for any amount not covered by insurance.

PAYMENTS: All professional services rendered are charges to the patient's parent(s) or legal guardian(s) who are responsible for payment of fees. Payment for office services is due at the time services are rendered unless other arrangements have been made in advance with our personnel.

APPOINTMENTS: A minimum charge will be applied for failed appointments without prior notification.

FEES: A minimum charge will be applied for all returned checks. A late charge will be applied to all accounts more than thirty days past due. In the event of non-payment, I agree to pay reasonable attorney fees, court costs, collection agency fees, and other expenses necessary for collection.

**I have read and understand the above stated policies**

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_