Pediatric Associates of Plymouth, Inc.

3031 Walton Road, C101
Plymouth Meeting, PA 19462

50 West Third Ave., Suite 400
Collegeville, PA 19426

Date: ____________

Family Last Name _________________________

Mother's Full Name _________________________

Father's Full Name _________________________

Address ___________________________________

____

____

Home Phone # ______________________________

Name & Address of Person Responsible for Bill

(*if different than above*)

____

____

____

Emergency Contact Name & Phone #

____

Blue Book Given? Y N Referred By _______________

<u>Children's Full Names, Dates of Birth & SS#'s</u>

1. _____________________________________
2. _____________________________________
3. _____________________________________
4. _____________________________________
5. _____________________________________
6. _____________________________________

Primary Insurance Co. ___________________________

Policy Holder ___________________________

ID # ___________________________________

Group # _______________________________

Effective Date: _________________________

Secondary Insurance Co. ________________________

Policy Holder ___________________________

ID # ___________________________________

Group # _______________________________

Effective Date: _________________________

Father's Social Security # ________________________

Date of Birth ___________________________

Place of Employment _____________________

Work Phone # ___________________________

Cell Phone # ____________________________

Mother's Social Security # _______________________

Date of Birth ___________________________

Place of Employment _____________________

Work Phone # ___________________________

Cell Phone # ____________________________

<u>Financial Responsibility:</u> *I authorize Pediatric Associates of Plymouth to release any medical information to my insurance companies to determine benefits and payable benefits for related services. I understand that I am financially responsible for any balance not covered by my Insurance Companies. I understand I am responsible for all co-pays due at the time of the visit. My signature indicates that I have read the above and agree to the terms and conditions.*

Signature: ________________________________

Date: ________________________________