

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 \_\_\_\_\_

**Children's Full Names, Dates of Birth & SS#'s**

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 # \_\_\_\_\_

**Financial Responsibility:** 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: \_\_\_\_\_