ADVANCED PEDIATRICS

CHART # ____________________
DATE ______/______/ 2006

DATE OF BIRTH SOCIAL SECURITY #

FATHER/LEGAL GUARDIAN ________________________ ___/___/____ __________________

MOTHER/LEGAL GUARDIAN ________________________ ___/___/____ __________________

BILLING ADDRESS: STREET ____

CITY ________________________ STATE __________ ZIP ________

TELEPHONE: **HOME** ____________________

	PARENT/GUARDIAN	EMPLOYER
WORK ____________________	FOR ____________________	AT ______________________________
WORK ____________________	FOR ____________________	AT ______________________________

CELL ______________________________ (MOTHER) CELL ______________________________ (FATHER)

E-MAIL ADDRESS:______________________________

WITH WHOM DO CHILDREN RESIDE: ☐ BOTH PARENTS ☐ MOTHER ONLY ☐ FATHER ONLY

CHILDREN'S ADDRESS: STREET ____

(IF DIFFERENT FROM ABOVE)
CITY ______________________________ STATE ____________________ ZIP ____________________

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ____________________ ☐ FRIEND/RELATIVE ____________________
☐ ADVERTISEMENT __________ _____ ☐ OTHER ______________________________

NAME/ADDRESS/PHONE # OF YOUR PHARMACY: ____

AUTHORIZATION FOR TREATMENT

I HEREBY AUTHORIZE ANY PHYSICIAN OF ADVANCED PEDIATRICS; OR NURSE - UNDER THE SUPERVISION OF A PHYSICIAN OF ADVANCED PEDIATRICS, TO RENDER MEDICAL TREATMENT, WHICH IN HIS/HER JUDGMENT MAY BE DEEMED NECESSARY FOR THE CARE OF THE FOLLOWING CHILDREN:

FIRST NAME, MI, LAST NAME (IF DIFFERENT)	SEX M	SEX F	DATE OF BIRTH MO DAY YR	SOCIAL SECURITY #
______________________________	☐	☐	______/______/______	____________________
______________________________	☐	☐	______/______/______	____________________
______________________________	☐	☐	______/______/______	____________________
______________________________	☐	☐	______/______/______	____________________

SIGNATURE OF PARENT OR GUARDIAN ____ DATE ____________________

INSURANCE INFORMATION

INS CO NAME: ______________________________ SOCIAL SECURITY # OF SUBSCRIBER ____________________ CO-PAYMENT __________

POLICY HOLDER'S NAME ____ BIRTHDATE OF POLICY HOLDER ______/______/______

POLICY HOLDER'S EMPLOYER ____________________ ID # OF POLICY ____________________ GROUP # ____________________

REFERRAL REQUIRED? ☐ YES ☐ NO INSURANCE CO PHONE NUMBER ______________________________

PAYMENT IS DUE AT TIME OF SERVICE

(THE POLICY IN OUR OFFICE IS THAT THE PARENT/GUARDIAN WHO REQUESTS TREATMENT FOR THE CHILD(REN) IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.)

PLEASE READ CONDITIONS OF REGISTRATION ON THE BACK OF THIS FORM