PEDIATRIC SERVICES OF SPRINGFIELD, INC.

PATIENT S NAME____

DATE OF BIRTH____

ADDRESS____
____
____

SIBLING(S)____

HOME PHONE#____

PARENT S NAME____

RESPONSIBLE PARTY NAME____

ADDRESS____
____
____
____

PARENT S WORK PHONE#________________(MOM OR DAD) PLEASE CIRCLE

EMERGENCY CONTACT___________________PHONE #__________________

INSURANCE INFORMATION

INSURANCE COMPANY____

POLICY #____________________________GROUP #________________________________

SUBSCRIBER S NAME____

DATE OF BIRTH________________________EMPLOYER_____________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY____

POLICY #____________________________GROUP #________________________________

SUBSCRIBER S NAME____

DATE OF BIRTH________________________EMPLOYER_____________________________

I hereby authorize payment directly to Pediatric Services of Springfield, Inc. all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges not covered/paid by my insurance.

PARENT S SIGNATURE___________________________DATE:_________________________