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HarvardFamilyMedicine.com

Pediatric Patient Information

Date:_____ How did you hear about us?_____

Child's Last Name:_____ Child's First Name: _____ M.I.:_____

Social Security #: _____ Date of Birth:_____ Gender: M ☐ F ☐

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: (____) _____

Child's Current Grade Level: _____ Pharmacy and Location:_____

Father's Name: _____ SSN:_____ DOB:_____

Father's Mobile Phone: _____ Work Number:_____

Mother's Name: _____ SSN:_____ DOB:_____

Mother's Mobile Phone:_____ Work Number:_____

Primary Insurance Information: (Required Information)

Policy Holder Name: _____ Policy Holder SS#:_____

Policy Holder DOB: _____ Policy Holder Employer:_____

Policy Holder Insurance Company: _____

Secondary Insurance Information: (Required Information)

Policy Holder Name: _____ Policy Holder SS#:_____

Policy Holder DOB: _____ Policy Holder Employer:_____

Policy Holder Insurance Company: _____

Emergency Contact Other Than Parent: (Required Information)

Name: _____ Contact Number:_____ Relationship to Child:_____

Second Contact Other Than Parent:_____ Phone Number: (____) _____

Assignment of Insurance Benefits

The undersigned herby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim. I will be bound by this signature as though the undersigned had personally signed the particular claim for me or my dependents.

I hereby authorize the above insurance(s) to pay and hereby assign directly to Harvard Family Medicine all benefits, if any, otherwise payable to me for his/her service as described on the attached forms. I understand I am financially responsible for all changes incurred. I further acknowledge that any insurance benefits, when received by and paid to Harvard Family Medicine will be credited to my account, in accordance with the above assignments.

_____ _____

Authorized Signature of Policy Holder Date

_____ _____

Parent / Guardian Signature Date