FARMINGTON VALLEY PEDIATRICS

PATIENT INFORMATION
(Please complete in full & sign back of form)

DATE:_____

Patient Name:_____
last, first, middle

Gender:_____ Date of Birth:_____

Street Address:_____

City:_____State:_____ Zip:_____ Tel #: (____)_____

Primary Phone#_____ **2nd Phone#** _____

Primary Email:_____

Parent 1 Name:_____ Birth date:_____

Street Address:_____

City:_____ State:_____ Zip:_____ Tel #: (____)_____

Parent 1 Employer:_____ Cell #: (____)_____

Parent 2 Name:_____ Birth date:_____

Street Address:_____

City:_____ State:_____ Zip:_____ Tel #: (____)_____

Parent 2 Employer:_____ Cell #: (____)_____

Primary Insurance:_____Effective date: _____

ID#:_____Group # or name: _____

Policy holder Name:_____ Co-pay amount:_____

Secondary Insurance:_____ Effective date:_____

ID#:_____ Group # or name:_____

Policy holder Name:_____ Co-pay amount:_____

Siblings Names:_____

TURN OVER

ASSIGNMENT OF BENEFITS

I authorize Farmington Valley Pediatrics, LLC to bill my Health Insurance Plan directly. I authorize payment of medical benefits be made directly to Farmington Valley Pediatrics, LLC. This is to include primary and secondary insurance plans. I agree to pay all charges incurred by me that are not reimbursed by my Health Insurance Plan(s).

_____ _____

PATIENT/GUARANTOR SIGNATURE DATE

_____

RELATIONSHIP TO PATIENT