Boca Pediatric Group

<u>Please give the receptionist your insurance card!</u>

**** Please PRINT CLEARLY ****

Father's Name (first and last)____
Address ____
City,State,Zip ____
Home Phone__________________Work #__________________Cell#________________
Date of Birth__________________Social Security # ______________________________
Employer: ______________________Occupation: ________________________________
Email address ____

Mother's Name (first and last)____
Address (**if different than Father's**)____
City,State,Zip____
Home Phone __________________Work#________________Cell#__________________
Date of Birth__________________Social Security#______________________________
Employer: ______________________Occupation:_________________________________
Email address ____

CHILDREN'S INFORMATION

****Please write First AND Last name**** ***Complete DOB*** ***Circle Male or Female***
Child's Name __________________________ Date of Birth_________________M / F
Child's Name___________________________Date of Birth_________________M / F
Child's Name___________________________Date of Birth_________________M / F
Child's Name___________________________Date of Birth_________________M / F

INSURANCE INFORMATION – PLEASE GIVE YOUR CARD TO THE FRONT OFFICE

Name of Insurance Company____
Identification or Policy #____
Policyholder's Name________________________________ DOB____________________
Relationship to child____

Referred by____
Primary Language spoken in home_____________Are translation services needed?__________

I hereby authorize payment of medical benefits to Boca Pediatric Group for any and all services rendered and understand that I am responsible for any copayment and/or non-covered insurance charges. I also authorize the release of medical information necessary for the processing of insurance claims.

☞ *PARENT/GUARDIAN
SIGNATURE____DATE__________________