Metropolitan Pediatrics

PATIENT DEMOGRAPHICS AND INSURANCE

Parent Name:		Relationship:	☐Mother ☐Father ☐Step-Mother ☐Step-Father
Address:		Apartment #:	
City:		State:	Zip:
Home Phone:		Cell Phone:	
Employer:		Position:	
Address:		Work Phone:	
Social Security #:		Date of Birth:	
E-Mail Address:			

Parent Name:		Relationship:	☐Mother ☐Father ☐Step-Mother ☐Step-Father
Address:		Apartment #:	
City:		State:	Zip:
Home Phone:		Cell Phone:	
Employer:		Position:	
Address:		Work Phone:	
Social Security #:		Date of Birth:	
E-Mail Address:			

Marital Status: (In cases of parental separation, we bill the custodial parent.)	Married:		Single:		Divorced:		Widowed:	

Primary Insurance:		**Secondary Insurance:**	
Name:		Name:	
Group Number:		Group Number:	
ID #:		ID #:	
Policy Holder:		Policy Holder:	
Effective Date:		Effective Date:	

Please list children in your household that are patients at Metropolitan Pediatrics:

Full Name:	**Date of Birth:**	**Gender (M/F):**

Name of nearest relative or friend not at patient's address: Relationship: Phone Number: ( )

AUTHORIZATION AND RELEASE:

I authorize the release of information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the Metropolitan Pediatrics group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual billed amount. I agree to pay all services rendered on my behalf or my dependents.

Signature: Date: