AMBLER PEDIATRICS

602 S. BETHLEHEM PIKE, AMBLER, PA 19002

PATIENT INFORMATION – *Please complete all sections*

LAST NAME_____ **FIRST NAME**_____ **MIDDLE NAME**_____ **Suffix** _____

DOB _____ **SEX: M F** **SOC SEC#** _____-_____-_____

ADDRESS Street_____ **Apt#** _____

City_____ **State**_____ **Zip** _____-_____

HOME/PRIMARY PHONE#_____

ETHNICITY (circle one) Hispanic(H) Non-Hispanic (N) Declined(7)

RACE (circle) American Indian/Alaskan Native(I) Asian(A) Black(B) Caucasian (C) Pacific Island (P) Other(E) Declined(7)

PRIMARY LANGUAGE SPOKEN (circle one)

English Spanish Russian Korean Japanese Other_____

SIBLINGS (If applicable) (first, middle, last)

_____ **DOB**_____

_____ **DOB**_____

_____ **DOB**_____

PARENT/GUARDIAN #1 Legal Guardian? Y or N FATHER / MOTHER /_____ (circle)

LAST NAME_____ **FIRST NAME**_____ **MIDDLE NAME**_____

DOB _____ **SOC SEC#**_____ - _____ - _____ **MARITAL STATUS**_____

ADDRESS (if different from above)

Street_____ **Apt#** _____

City_____ **State**_____ **Zip** _____-_____

Occupation_____ **Employer name**_____

Address_____ **Phone**_____

CONTACT INFO

Home phone_____

Cell phone_____

Email _____

(only for appointment reminders)

PARENT/GUARDIAN #2 Legal Guardian? Y or N FATHER / MOTHER /_____ (circle)

LAST NAME_____ **FIRST NAME**_____ **MIDDLE NAME**_____

DOB: _____ **SOC SEC#**_____ - _____ - _____ **MARITAL STATUS**_____

ADDRESS (if different from above)

Street_____ **Apt#** _____

City_____ **State**_____ **Zip** _____-_____

Occupation_____ **Employer name**_____

Address_____ **Phone**_____

CONTACT INFO

Home phone_____

Cell phone_____

Email _____

(only for appointment reminders)

I certify that the above information I have furnished is true and correct. I know it is a crime to fill this form with facts I know are false or leave out facts I know are important. ***(must be signed by both parents/guardians)***

(circle below)

Print name- Parent/Guardian #1	Signature	Mother / Father / Other Relationship to Patient	Today's Date
Print name- Parent/Guardian #2	Signature	Mother / Father / Other Relationship to Patient	Today's Date

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OTHER PERSONS AUTHORIZED TO ACCOMPANY PATIENTS DURING VISITS (if applicable) ***(If you give permission for them to authorize vaccine administration, please indicate below)***		
First & last name _____	***vaccine- YES*** □	**Relationship to patient**_____
First & last name _____	***vaccine- YES*** □	**Relationship to patient**_____

FINANCIAL RESPONSIBILITY

I/We, _____ am/are financially responsible for minor patient(s)
(parents/guardians)
_____. We hereby authorize my child's insurance company to pay the
(patient's name)

proceeds of any benefits due me exactly to **Ambler Pediatrics**. We acknowledge and understand that we are responsible for payment for all the services rendered to any member of our family.
Although we have requested the doctor to bill the child's insurance company on our behalf, we clearly understand that it is still our responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of a bill is not paid by the child's insurance company, we further agree to make arrangements for prompt payment of the bill.

MEDICAL RELEASE AUTHORIZATION **(must be signed by both parents/guardians)**

I authorize release of my child's records to his/her insurance company, if information is requested with regards to processing claims. I certify that the information I furnish is true and correct. I know it is a crime to fill this form with facts I know are false or leave out facts I know are important.

_____	**Mother / Father / Other**	_____
Signature- Parent/Guardian #1	**Relationship to Patient**	**Today's Date**
_____	**Mother / Father / Other**	_____
Signature- Parent/Guardian #2	**Relationship to Patient**	**Today's Date**