WELCOME TO ALLENTOWN PEDIATRIC & ADOLESCENT MEDICINE, LLP

Patient's Name: _____Date of Birth: _____ Gender: Male Female

Address: _____City: _____Zip Code: _____

Main Phone#: _____Alternate Phone #:_____Emergency Contact #: _____

Email Address: _____

Primary Language: English Spanish Other _____ Race: _____

Parent: _____Date of Birth: _____Phone: _____

Parent: _____Date of Birth: _____Phone: _____

Legal Guardian if not parent: (Need to provide documentation)

Name: _____Date of Birth: _____Phone: _____

The Child lives with (please circle): Both Parents Mom Dad Legal Guardian

HEALTH INSURANCE INFORMATION: We are required to have a copy of your insurance card on file

Name of Insurance: _____Patient ID: _____

Policy Holder: _____Group/Sequence# : _____

Policy Holder's Employer: _____Copay $_____

PHARMACY: Please provide us with the name and phone number of your pharmacy. This helps us to send your prescriptions to the correct pharmacy when a medication is ordered.

Name _____ Phone Number: _____

PLEASE LIST ANY SIBLING(S) THAT IS CURRENTLY PATIENTS OF ALLENTOWN PEDIATRIC & ADOLESCENT MEDICINE:

Name: _____Date of Birth: _____

Name: _____Date of Birth: _____

Name: _____Date of Birth: _____

--OVER--

I hereby assign medical benefit payment of any and all services rendered by Allentown Pediatric & Adolescent Medicine, LLP and I understand that I am **fully responsible** for any charges my **policy does not cover** including deductibles and co-payments and will be personally billed for such. I authorize the practice to release any information needed to secure payment for services rendered.

NOTE: In the event we are **NOT listed as the PCP** or the office staff is not able to verify active insurance coverage on the date of your appointment, we reserve the right to ask you for payment in full to receive physician services at the time of the appointment or ask you if you want to reschedule for a later date or to cancel the appointment.

By signing below, I acknowledge that all the information I have provided is true and correct.

Parent or Legal Guardian Signature:_____ Date:_____

Relationship to patient:_____

I agree to reimburse Allentown Pediatric & Adolescent Medicine, LLP the fee for any collection agency should I not pay what my insurance company deems is my responsibility. The fee may be based on a percentage at a maximum of 33% of the debt and all costs and expenses, including reasonable attorney fees and court costs we may incur in such collection efforts. The agency or law office may report to one or more credit reporting agencies.

Signed by:_____ Date:_____

I hereby consent to receive autodialed, pre-recorded or SMS Text calls from or on behalf of Allentown Pediatric & Adolescent Medicine, LLP at the telephone number provided to the office, including wireless number(s) provided. I understand that consent is not a condition of purchases or services received.

Signed by:_____ Date:_____