Kendall Pediatric Partners

PATIENT INFORMATION:

Name: _____ Date of Birth: _____
Last First

M ( ) F ( ) Child lives with: Father_____ Mother _____ Both _____ Other _____

Address: _____ZIP_____

Primary Phone _____ Alternate Phone _____

Email : _____

Pharmacy and phone #: _____

Parents' Marital Status: Married _____ Separated _____ Divorced _____

Languages spoken at home: English_____ Spanish____ Other_____

Siblings in the office: _____

INSURANCE POLICY HOLDER INFORMATION:(PERSON)

Name: _____ Date of Birth:_____

Address (If different from above)_____

Phone Number _____SS#: XXX-XX-_____ Employer: _____

Email address: _____

OTHER PARENT INFORMATION:

Name: _____

Address: (if different from above) _____

Phone Number _____

Your appointment time has been set aside for you alone; no other patients are scheduled at the same time. If you can't keep it, kindly cancel in advance. There will be a $ 30 charge for missed appointments.

I authorize kendall pediatrics to email specialist referral information. Yes _____ No ____

Initials: _____

I hereby authorize payment, directly to Kendall Pediatric Partners, LLC, of benefits due to me from my insurance company, otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges, lab work and vaccines not covered by my insurance contract as performed in the office, and for any co-payments and/or deductible amounts as specified in my insurance contract. I acknowledge that Private Health Information material (HIPAA) is posted, and available upon request

_____ _____ _____

Parent Name Signature Date