ROYAL PALM PEDIATRICS
11903 Southern Blvd., Ste 118
Royal Palm Beach, FL 33411
Ph: (561)429-5898 Fax: (561)429-5897

PATIENT INFORMATION

Name of the Child: _____ Age: _____ Sex: M_____F_____

Date of Birth: _____Primary Language Spoken: _____Parents Email Address: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone #: _____Cell Phone #:_____Work Phone #: _____

Mother's Name: _____Father's Name: _____

Primary Caregiver: _____ Relationship to Child: _____

Legal or Custody Issues: Yes or No (If Yes: Please provide Legal Documents) Legal Documents Provided: Yes or No

Person(s) other than you who can bring the child in for treatment?_____

Pharmacy Name: _____ Pharmacy Phone #: _____ Pharmacy Address: _____

EMERGENCY CONTACT

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Name of Primary Insurance Plan: _____

Person Financially Responsible: _____ Policy Holders Date of Birth: _____

Primary Insurance Holder:Mother_____ Father___ Guardian_____ Other_____

Policy Number: _____ Group Number: _____

Name of SecondaryInsurancePlan: _____

Person Financially Responsible: _____Policy Holders Date of Birth:_____

Secondary Insurance Holder: Mother_____ Father___ Guardian_____ Other_____

Policy Number: _____Group Number: _____

RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by Insurance with _____and assign directly to Dr. Mohan at Royal Palm Pediatrics. All insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my Insurance. I hereby authorize the doctors to release all information necessary to secure the payments and benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Royal Palm Pediatrics will be turning my account over to collection agency if they do not receive a response in 30 days. Their fees will be added to my balance due. This will increase my balance by 25%. I understand that I am financially responsible for all charges regarding copies of medical records.

_____ _____

Parent/Guardian Date