

# Monument Avenue Pediatrics

## Personal Information Form

for patients 17 years old and younger

List All Children Below (children under 18 years of age and are our current patients)

1. \_\_\_\_\_  
(Last) (First) (M.I.) (Date of Birth) (Sex)
2. \_\_\_\_\_  
(Last) (First) (M.I.) (Date of Birth) (Sex)
3. \_\_\_\_\_  
(Last) (First) (M.I.) (Date of Birth) (Sex)
4. \_\_\_\_\_  
(Last) (First) (M.I.) (Date of Birth) (Sex)

\*\*Add additional children on back\*\*

Children reside with: \_\_\_\_\_

### Mother / Guardian

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip code \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Email \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

### Father / Guardian

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Preferred method of contact (Please ✓) Text \_\_\_\_\_ Voice Message \_\_\_\_\_ Email \_\_\_\_\_ Mail \_\_\_\_\_

Should your child have an emergency (accident, seizure) in our office, who should we contact (other than parent)?

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Insurance Information**

Do you have insurance coverage for all of the patients listed above? Y N

**Please provide your insurance card today and each time your child is seen in our office.**

Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Number \_\_\_\_\_

Subscriber's name and relationship to the patient \_\_\_\_\_

Birthday of Subscriber \_\_\_\_\_

I hereby authorize Monument Avenue Pediatrics, P.C. to release information requested to the insurance company named herein, understand that, as a courtesy, you will file appropriate claims with my insurance company. I hereby assign payment of benefits to the above named physicians. **I understand that I am financially responsible for charges not covered by my insurance company. I understand that if my insurance company does not remit payment within 60 days that I will be expected to pay the bill.** I agree that in the event that my account must be turned over to an attorney for collection, that I will be responsible for the attorney's fees, court costs, and interest. **Fees incurred are payable when services are rendered and are the sole responsibility of the parents and/or guardian.**

Mother's Signature \_\_\_\_\_ Date \_\_\_\_\_

Father's Signature \_\_\_\_\_ Date \_\_\_\_\_