Monument Avenue Pediatrics
Personal Information Form

for patients 18 years old and older

Name Below:

_____

(Last) (First) (M.I.) (Date of Birth) (Sex)

With whom do you reside? _____

Self	**Parent / Guardian**
Name _____	_____
Address _____	_____
City _____ Zip code _____	_____
Social Security # _____	_____
Employer _____	_____
Email _____	_____
Work Phone _____	_____
Home Phone _____	_____
Cell Phone _____	_____

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

Should you have an emergency (accident, seizure) in our office, who should we contact?

Name _____ Phone _____

continued

Insurance Information

Do you have insurance coverage for yourself? Y N

Please provide your insurance card today and each time your are 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.**

Signature _____ Date _____