Pediatric Endocrine Associates

Patient Name____________________ **Circle one**: Male / Female **Race**: _____________
Date of Birth ____________Social Security: ______________ **Preferred Language**:________
Address____Apt#____________________
City _________State ________Zip______ Phone# ( ) ______________***Home or cell***
Phone#:( )_______________ ***Home or Cell*** **[ ] Okay to text**
Mobile Carrier _____________________

Policy Holders Information (<u>If patient is a minor please enter parents information</u>)
Name: __________________________________Social Security: ________________________
Date of Birth: ______________ Relationship to patient: ________________________________

Parent / Guardian Email: ____

Insurance Information:
Primary Insurance: ___________________ Member# ___________________Grp.____________
Secondary Insurance: __________________Member ID#: _________________ (Please note that we will bill your secondary insurance ONCE on your behalf as a courtesy. Payment is your responsibility.

Primary Care Physician:
Dr. Name ______________________________ Phone# _________________ Fax#___________

Pharmacy Name:___________________Street Name: ________________Phone#___________

I understand that I am responsible for providing the office with the correct information.
I agree that all the information provided above is correct.
By signing my name, I authorize the medical information to be released to my insurance for billing purposes and for medical care of the patient. I also authorize payment of medical benefits of the above patient to Dr. Lin and Dr. DeClue for services received.
By signing my name, I take legal responsibility of providing correct insurance information to Dr.Lin and Dr. DeClue for the service delivered. Any parent or legal guardian (regardless of martial status) who brings a minor in for treatment is, and hereby agrees to be responsible for paying the minors account in full. If the information provided is incorrect or incomplete; I will be responsible for covering the charges on the date the services were rendered**.** If patient account is sent to *collections*, patient(s) will also be *discharged from this practice.*

Signature: ____ **Date:** ___________________

Print Name: ______________________________**Relationship to patient:** ______________________

Please note that those patients who **<u>DO NOT CALL</u>** within the allowed time **<u>WILL BE CHARGED a $25 FEE</u>**. This is a **<u>NON-COVERED</u>** service and as such is not payable by insurance. Thank you for your understanding in this matter.

Signature: ____ **Date:** ___________________________

____________________FUTURE APPOINTMENTS ONLY______________________________

I agree that the above information (insurance, address, telephone# and PCP) is still correct and complete as of today's date.
1.Date:__________ Signature:________________________My insurance is the same as above (YES NO)
Is there secondary Insurance (YES NO)
2.Date:__________ Signature:________________________My insurance is the same as above (YES NO)
Is there secondary Insurance (YES NO)
3.Date:__________ Signature:________________________My insurance is the same as above (YES NO)
Is there secondary Insurance (YES NO)