

Cranford Pediatrics
Patient Information

Last Name: _____

List Children: _____

Birthdate: _____ Sex _____

Birthdate: _____ Sex _____

Birthdate: _____ Sex _____

Birthdate: _____ Sex _____

Birthdate: _____ Sex _____

Street Address: _____

Home City: _____ State: _____ Zip: _____

Home Phone #() _____ Cell Phone if age > 16 years () _____

Father Work Phone#() _____ Father Cell Phone#() _____

Mother Work Phone#() _____ Mother Cell Phone#() _____

Email _____ Mother's Maiden Name _____ D.O.B _____

Insurance Information

Primary Insurance Company Name: _____

Primary Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Co. Phone#() _____ Policy Holder SSN# _____

Policy Holder Last Name: _____ First Name: _____

Address of Policy

Holder if Different than Child: _____

Policy Holder Date of Birth: _____ Relationship to Patient: _____

Insurance ID# _____ Group# _____

Pharmacy: _____ Phone#() _____

I authorize the release of any medical information necessary to process all claims and request payment of benefits to Cranford Pediatrics. I accept full financial responsibility for treatment provided to my family. If my insurance fails to pay for services rendered, or if I fail to pay for my share of charges when billed (including co-pays prior to service and the \$25.00 missed appointment fee) I agree to pay a \$10.00 repeat billing charge per bill, and for all collections costs after six months of billing.

Parent Signature: _____ Date: _____