HANOVER PEDIATRIC ASSOCIATES, P.C.

Acct # **Date**

SSN: **Sex:** **Patient Age:** **Date of Birth:**

First Name: **Middle:** **Last:**
Address: **City:** **St:** **Zip:**
Home Phone:
Guarantor:
Guarantor Address: **City:** **State:** **Zip:**
Guarantor SS#: **Guarantor phone #** **Guarantor DOB:**
Name of person to notify in case of emergency: **Phone:**
Relationship to contact:

Is an Emergency Authorization On File? ____ Yes ___ No

May we leave a detailed message at home? ____Yes ____No At Work? ____Yes ____No On Cell? ___Yes ___No

What pharmacy do you use? ______________________________

INSURANCE INFORMATION

WE WILL NEED YOUR CURRENT INSURANCE CARD AND YOUR DRIVERS LICENSE. PLEASE GIVE TO RECEPTIONIST TO MAKE COPIES.

PRIMARY INSURANCE

Company: **Address:**
Member ID# **Group#**
Subscriber: Self___ Spouse___ Guardian ___
Subscriber's Name: **DOB:**
Address:

SECONDARY INSURANCE

Company: **Address:**
Member ID# **Group#**
Subscriber: Self___ Spouse___ Guardian ___
Subscriber's Name: **DOB:**
Address:

This is my consent for treatment for my minor dependent by Hanover Pediatric Associates, P.C. I understand and agree that regardless of any insurance status I am responsible for the balance on my account for medical services rendered. I authorize payment directly to and assign Hanover Pediatric Associates, P.C. medical benefits. I also grant release of information for any insurance claims filed in my name or my dependents. If I fail to fulfill my financial obligation to Hanover Pediatric Associates, P.C. and my account is sent to an outside collection agency, I have been advised that an administration fee of 23% of the total outstanding balance will be added to my account. A $40.00 after hours fee will be charged to all after hours appointments effective 1/1/11.

X____ __________
Signature of patient/guardian/responsible party Date