Patient Profile

Patient's Name (First,Middle Initial, Last)
Patient's Address
City State Zip
Tel# Date of Birth Sex
Brother/Sisters Names:

Person other than parents to contact in case of Emergency
Name: _____

Telephone:

Referring Physician:_____
Where did you find out about our practice?

Insurance Co_____

Primary Insured Name_____

ID#

Mothers Name	Father's Name
Address	Address
City State Zip	City State Zip
Telephone Date of Birth	Telephone Date of Birth
SS#	SS#
Cell #	Cell#
Email Address	Email Address
Mother's Employer	Father's Employer
Address	Address
City State Zip	City State Zip
Work Tel#	Work Tel#
I authorize Pediatric Specialties PA to provide pertinent Records to any insurance company. x_____	I authorize Pediatric Specialties PA to provide pertinent Records to any insurance company. x_____

Thank you for choosing Pediatric Specialties PA to provide your child with the finest quality care.

The following is a statement of financial policy, which we require you to read and sign prior to initial treatment.

Patients with insurance: All Co-payments are payable at time of service. A $10.00 administrative charge will apply for non-payment on day of service. There is a $50.00 charge for missed appointments unless cancelled with 24 hour notice.
Patients without insurance: Full payment is due at time of service.
We accept cash, checks, credit/debit cards. A $30.00 fee will be imposed for any returned checks/credit/debit card payments.

As a courtesy we will bill your insurance carrier. If payment is not received within 60 days the "Responsible Party" will be billed the outstanding balance. Please let us know in advance if you have any questions about our policy.
I acknowledge that I have provided the above information correctly and accept responsibility for any outstanding balance due.

Signature:_____Date_____