Chesapeake Pediatrics Patient Information

Today's Date: _____ Child's Physician: _____ Sex M( ) F( )

Child's Last Name _____ Child's First Name _____ MI _____

Date of Birth _____ Child's Social Security # _____ Child Resides with _____

Mother's Full Name _____ Date of Birth _____ Maiden Name _____ SSN# _____

Mother's Street Address _____ City _____ State _____ Zip Code _____

Mother's Employer _____ Mother's Occupation _____

Mother's Home # _____ Cell Phone # _____ Work Phone # _____

Father's Full Name _____ Date of Birth _____ SSN# _____

Father's Street Address _____ City _____ State _____ Zip Code _____

Father's Employer _____ Father's Occupation _____

Father's Home # _____ Cell Phone # _____ Work Phone # _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ Effective. Date: _____

ID# _____ Group: _____

Subscriber Name: _____ Patients Relationship to Subscriber _____

SECONDARY INSURANCE NAME: _____ Effective. Date: _____

ID# _____ Group: _____

Subscriber Name: Patients Relationship to Subscriber

If Parent Cannot Be Reached Please Call _____ Phone # _____

Relationship to Child _____

STATEMENT OF RESPONSIBILITY

* The policy of this office is the parent or legal guardian who requests treatment for this child is responsible for all fees and services rendered. Any payments and insurance co-payments are expected the day of service unless arrangements are made in advance. Any remaining balances after insurance payments are also that of the insured. By signing, I give permission to have any insurance reimbursements paid directly to Chesapeake Pediatrics, unless other arrangements are indicated. By signing this document I agree to pay 18% interest per annum on my balance due after 30 days. I also understand and agree that if my personal check is returned for this back for any reason. I will pay a $35.00 returned fee and my personal checks will no longer be accepted as payment for services rendered.*

_____ _____

Parent or legal Guardian Signature Please Print Name