MILFORD PEDIATRIC GROUP
PATIENT INFORMATION SHEET

LIST ALL CHILDREN	DOB	M/F	ETHNICITY	INSURANCE ID NUMBER

PRIMARY INSURANCE: _____ **SUBSCRIBER NAME:** _____
SUBSCRIBER DATE OF BIRTH: _____ **GROUP NO:** _____

SECONDARY INSURANCE (if any): _____ **SUBSCRIBER NAME:** _____
SUBSCRIBER DATE OF BIRTH: _____ **GROUP NO:** _____

PREFERRED LANGUAGE: _____

PARENTS MARITAL STATUS: ( ) MARRIED ( ) DIVORCED ( ) SEPARATED ( ) WIDOWED ( ) SINGLE

MOTHERS NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY N0: _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMAIL: _____ EMPLOYER: _____
PHONE NUMBERS **CHECK PREFERRED**: ( ) HOME: _____ ( ) CELL: _____ ( ) WORK PHONE: _____

FATHERS NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY N0: _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMAIL: _____ EMPLOYER: _____
PHONE NUMBERS **CHECK PREFERRED**: ( ) HOME: _____ ( ) CELL: _____ ( ) WORK PHONE: _____

LEGAL GUARDIAN NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY N0: _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMAIL: _____ EMPLOYER: _____
PHONE NUMBERS **CHECK PREFERRED**: ( ) HOME: _____ ( ) CELL: _____ ( ) WORK PHONE: _____

FINANCIAL RESPONSIBILITY

The insurance policy held by you is a contract between the policy holder and your insurance company. YOUR CHILDREN are our patients, not the insurance company.

If you are not familiar with your coverage, please contact your insurance company directly prior to the visit. This office is not responsible for knowing what your exact coverage is.

I understand that I am financially responsible for any charges incurred by my child(ren) and agree to pay promptly regardless of insurance. This includes, but is not limited to; deductibles or co-insurances. I also understand that co-payments are payable at the time of the visit and I will incur an additional fee of $10 if I fail to do so. I further understand and agree to pay co-payments at the visit, despite what my divorce agreement might stipulate. Milford Pediatric Group is not a party in my divorce. In addition, I understand and agree to pay a charge of $15 if my account becomes delinquent and is sent to Transworld Systems for collection. I also understand I will be charged a fee if I fail to cancel any appointments with 24 hour notice or not cancel at all.

PARENT NAME: _____ DATE: _____

SIGNATURE: _____