AMBLER PEDIATRICS

602 S. BETHLEHEM PIKE, AMBLER, PA 19002

PATIENT INFORMATION – *Please complete all sections*

LAST NAME_____ **FIRST NAME**_____ **MIDDLE NAME**_____

DOB _____ **SEX: M F** **SOC SEC#** _____-_____-_____

ADDRESS Street_____ **Apt#** _____

City_____ **State**_____ **Zip** _____-_____

HOME PHONE#_____

RACE (circle one) American Indian/Alaskan Native(I) Asian(A) Black(B) Caucasian (C) Pacific Island (P) Other(E) Declined(7)

ETHNICITY (circle one) Hispanic(H) Non-hispanic (N) Declined(7)

PRIMARY LANGUAGE SPOKEN (circle one) English Spanish Russian Korean Japanese Other_____

SIBLINGS (If applicable) _____ **DOB**_____
(first, middle, last) _____ **DOB**_____

PARENT/GUARDIAN #1 **Legal Guardian? Y or N** **FATHER/MOTHER/_____ (circle)**

LAST NAME_____ **FIRST NAME**_____ **MIDDLE NAME**_____

DOB _____ **SOC SEC#**_____ - _____ - _____ **MARITAL STATUS**_____

ADDRESS (if different from above)

Street_____ **Apt#** _____

City_____ **State**_____ **Zip** _____-_____

Occupation_____ **Employer name**_____

Address_____ **Phone**_____

CONTACT INFO

Home phone_____

Cell phone_____

Email address_____

PARENT/GUARDIAN #2 **Legal Guardian? Y or N** **FATHER/MOTHER/_____ (circle)**

LAST NAME_____ **FIRST NAME**_____ **MIDDLE NAME**_____

DOB: _____ **SOC SEC#**_____ - _____ - _____ **MARITAL STATUS**_____

ADDRESS (if different from above)

Street_____ **Apt#** _____

City_____ **State**_____ **Zip** _____-_____

Occupation_____ **Employer name**_____

Address_____ **Phone**_____

CONTACT INFO

Home phone_____

Cell phone_____

Email address_____

OTHER PERSONS AUTHORIZED TO ACCOMPANY PATIENTS DURING VISITS (if applicable)

First and last name _____ **Relationship to patient**_____

First and last name _____ **Relationship to patient**_____

I certify that the above information I have furnished is true and correct. I know it is a crime to fill this form with facts I know are false or leave out facts I know are important.

PRINT NAME_____ **SIGNATURE**_____

Relationship to patient_____ **TODAY'S DATE**_____ **(OVER SIDE 2----)**

AMBLER PEDIATRICS

602 S. BETHLEHEM PIKE, AMBLER, PA 19002

GUARANTOR INFORMATION: Please complete all sections **(Financially responsible party)**		
LAST NAME:	**FIRST:**	**MIDDLE:**
STREET ADDRESS:		**APT #:**
CITY:	**STATE:**	**ZIP:**
DOB:	**SOCIAL SECURITY #:**	**MARITAL STATUS:**
HOME PHONE: ( )	**CELL PHONE: ( )**	
WORK PHONE: ( )	**E-MAIL ADDRESS:**	
RELATIONSHIP TO PATIENT:		

I, _____ am the guarantor (financially responsible party) for your minor patient
(as listed above)
_____. I hereby authorize my child's insurance company to pay the
(patient's name)
proceeds of any benefits due me exactly to **Ambler Pediatrics**. I acknowledge and understand that I am responsible for payment for all the services rendered to me or any member of my family.

Although I have requested the doctor to bill my child's insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my child's insurance company, I further agree to make arrangements for prompt payment of the bill.

MEDICAL RELEASE AUTHORIZATION

I authorize release of my child's records to his/her insurance company, if information is requested with regards to processing claims. I certify that the information I furnish is true and correct. I know it is a crime to fill this form with facts I know are false or leave out facts I know are important.

_____	_____	_____
Guarantor's Signature	**Relationship to Patient**	**Today's Date**