ESSEX PEDIATRICS

Patient Lives With	**Other Parent:**	**Send Bill To:**
Name:_____	_____	_____
Address:_____	_____	_____
Date of Birth::_____	_____	_____
Social Security #:_____	_____	_____
City:_____	_____	_____
State:_____ Zip Code:_____	Zip Code:_____	Zip Code:_____
Home Phone:_____	_____	_____
Alternate/Cell Phone: _____	_____	_____
Occupation:_____	_____	_____
Work Phone: _____	_____	_____
Relationship: _____	_____	_____

Primary Insurance Information:

Cardholder Name:_____ DOB of Cardholder: _____
Insurance Co Name: _____ Effective Date: _____
ID#: _____ Group #: _____
Employer: _____

Secondary Insurance Information

Cardholder Name: _____ DOB of Cardholder: _____
Insurance Co Name: _____ Effective Date: _____
ID #: _____ Group #: _____
Employer: _____

Medical Debit / Credit Card #_____ Exp date: _____
Please let us know if you would like to have monthly payments applied to your card or if you would like to apply payment in full. All credit card information is kept confidential.
Printed Name and Signature of card holder: _____

Active Children:	**DOB**	**Gender**	**Insco #**	**Medicaid #**	**Relationship**
_____	_____	M F	_____	_____	_____
_____	_____	M F	_____	_____	_____
_____	_____	M F	_____	_____	_____
_____	_____	M F	_____	_____	_____

I certify that I /my dependent have insurance coverage as indicated above. I hereby authorize Essex Pediatrics to apply for benefits on my/our behalf for all services rendered and assign directly to Essex Pediatrics all insurance benefits otherwise payable to me. I understand that all co pays are due at the time of service and that a billing fee will be added to any co pay not paid at the time of service. I further understand that if Essex Pediatrics is unable to verify coverage or charges are not paid by my insurance, I will be financially responsible and agree to remit the balance due immediately upon receipt of a bill. In the event that I do not pay my bill, I understand that I will be held responsible for all reasonable collection and legal fees. I understand that I, and not Essex Pediatrics, am responsible for understanding my insurance benefit information for all services provided to me.

Essex Pediatrics has provided me with a copy of the Notice of Privacy Practices.

Date: _____ Signed: _____ Staff Initials: _____