

# Pediatrics West, P.C.

**Patient/Child**  
Last Name \_\_\_\_\_ Address \_\_\_\_\_  
First Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Nickname \_\_\_\_\_ Zip \_\_\_\_\_ Phone# \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**Responsible Party Billing Information (Family Member responsible for payment)**  
Last Name \_\_\_\_\_ Address \_\_\_\_\_  
First Name \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_  
Responsible Party SS# \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Employer \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
Employer Phone # \_\_\_\_\_ Employer's Phone # \_\_\_\_\_  
Cell Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

**Primary Insurance Information**  
Insurance Company \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ (person who carries insurance)  
Subscriber's Date of Birth \_\_\_\_\_ Claims Address \_\_\_\_\_  
Subscriber's SS# \_\_\_\_\_ City \_\_\_\_\_  
Policy # \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Group # \_\_\_\_\_

**Secondary Insurance Information**  
Insurance Company \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_ Address \_\_\_\_\_  
Policy # \_\_\_\_\_ City \_\_\_\_\_  
Group # \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency Contact other than spouse**  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # \_\_\_\_\_

CHILD'S DOCTOR \_\_\_\_\_ REFERRED BY \_\_\_\_\_  
Please fill out this form completely. Please print legibly. THANK YOU!

**READ AND SIGN THE FOLLOWING STATEMENTS:**

I authorize for my family insurance benefits to be paid directly to this office and the release of pertinent medical information. I understand that I am financially responsible for any services not covered by my insurance and will comply with the office financial policy which includes payment in full at the time of service unless other arrangements have been made through this office. I agree that if it becomes necessary to forward my account to this office's collections agency, that, in addition to the amount owed, I will also be responsible for the reasonable cost of collection, including attorney fees.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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First Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Nickname \_\_\_\_\_ Zip \_\_\_\_\_ Phone# \_\_\_\_\_  
Date of Birth \_\_\_\_\_

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First Name \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_  
Responsible Party SS# \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Employer \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
Employer Phone # \_\_\_\_\_ Employer's Phone # \_\_\_\_\_  
Cell Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

**Primary Insurance Information**  
Insurance Company \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ (person who carries insurance)  
Subscriber's Date of Birth \_\_\_\_\_ Claims Address \_\_\_\_\_  
Subscriber's SS# \_\_\_\_\_ City \_\_\_\_\_  
Policy # \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Group # \_\_\_\_\_

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Subscriber's Name \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_ Address \_\_\_\_\_  
Policy # \_\_\_\_\_ City \_\_\_\_\_  
Group # \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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