PENNRIDGE PEDIATRIC ASSOCIATES, INC.
NEW PATIENT/CHANGE OF INSURANCE INFORMATION

Acct#_____

FATHER

Name: _____ **Birth Date:**___-___-___
Last First Middle

Marital Status: (circle one) **Single Married Divorced Widowed**

Race/Ethnicity: _____ **Preferred Language** _____

PO Box: _____ **Street Address:** _____

City: _____ **State** _____ **Zip:** _____

Phone# (home): _____ (work): _____ (cell) _____

Social Security #: ___-___-_____ **Employer:** _____

E-Mail Address: _____

Insurance Name: _____ **Group #:** _____ **ID#:** _____ **Effective Date of Coverage:**___-___-___

Do the children live at this address? ☐ yes ☐ no **If no, please give their address:**
Street address: _____
City/State/Zip: _____

MOTHER

Name: _____ **Birth Date:**___-___-___
Last First Middle

Marital Status: (circle one) **Single Married Divorced Widowed**

Race/Ethnicity: _____ **Preferred Language** _____

PO Box: _____ **Street Address:** _____

City: _____ **State** _____ **Zip:** _____

Phone# (home): _____ (work): _____ (cell) _____

Social Security #: ___-___-_____ **Employer:** _____

E-Mail Address: _____

Insurance Name: _____ **Group #:** _____ **ID#:** _____ **Effective Date of Coverage:**___-___-___

Do the children live at this address? ☐ yes ☐ no **If no, please give their address:**
Street address: _____
City/State/Zip: _____

Is current insurance provided by: ☐ Mother's Employer ☐ Father's Employer ☐ Both Employers

Is there dependent coverage on: ☐ Mother's Policy ☐ Father's policy ☐ Both Policies

Are all of the children covered? ☐ yes ☐ no **If no, list the names of the children not covered:**

_____ _____

_____ _____

Is baby covered for first 30 days only? _____

What insurance will be effective for the baby after 30 days? _____

Continued on the other side.....

Please list each child and their information below:

	Child's Name (first, last, middle initial)	**Sex**	**Birthdate**	**Social Security #**
____	_____	____	____-____-____	____-____-_____
____	_____	____	____-____-____	____-____-_____
____	_____	____	____-____-____	____-____-_____
____	_____	____	____-____-____	____-____-_____
____	_____	____	____-____-____	____-____-_____
____	_____	____	____-____-____	____-____-_____
____	_____	____	____-____-____	____-____-_____
____	_____	____	____-____-____	____-____-_____

Preferred Pharmacy/Location: _____

Person to contact other than parent in an emergency: _____

Phone# (home): _____(work):_____(cell) _____

How did you hear about our practice? **family/friend** _____ **PPA website** _____
local sports advertising _____ **newspaper advertising** _____ **township newsletter** _____

Pennridge Pediatrics will not bill your insurance company for any charges until all of the above information is provided. Your information is kept in strict confidence and will not be released to any entity for uses other than TPO without your written permission. You will be responsible to pay any bills that we cannot submit to the insurance company due to lack of information supplied on this form.

All charges not covered by your insurance must be paid at the time of the visit, including co-pays, unless prior arrangements have been made. All overdue balances over 60 days will be forwarded to a collection agency and a collection fee will be assessed.

As a courtesy to all our patients, please give us 24 hrs notice if you need to cancel an appointment.

I have read and agree to all conditions stated above and acknowledge I have been made aware of or received a copy of PPA's Notice of Privacy Practices. You may also view the notice on our website at: www.pennridgepediatrics.com.

_____ ____/____/____
Signature Date

_____
Printed Name

RECORD OF PHOTO ID

DOCUMENT #: _____
EXP. DATE: _____
SEC'Y INITIALS: _____

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