QUAKERTOWN PEDIATRICS
99 N. West End Boulevard, Suite 110 • Quakertown, PA 18951
Telephone: 215-536-1915 • Fax: 215-536-9189 • Email: drs@quakertownpediatrics.com

Patient's full name_____ **Age**_____ **DOB**_____ **Sex** _____

Address_____ **City**_____ **St**_____ **Zip** _____

Preferred Language: English Spanish Other (Please list) _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other Race

Any Known Allergies _____

Mother's name_____ DOB_____ Marital status _____

Address_____ City_____ St_____ Zip _____

Phone number_____ SS #_____ Driver's license _____

Cell phone number_____ Email address _____

Employer_____ Phone number _____

Address_____ City_____ St_____ Zip _____

Father's name_____ DOB_____ Marital status _____

Address_____ City_____ St_____ Zip _____

Phone number_____ SS #_____ Driver's license _____

Cell phone number_____ Email address _____

Employer_____ Phone number _____

Address_____ City_____ St_____ Zip _____

Referred by _____

In case of emergency contact (other than spouse)_____ Relationship_____

Address_____ City_____ St_____ Zip _____

Phone #_____ Cell phone #_____ Email address _____

Primary Coverage: Name of Carrier (copy card)

Group # _____

I.D.#_____

Subscriber_____

Subscriber DOB_____ Effective date _____

Secondary Coverage: Name of Carrier (copy card)

Group #_____

I.D.#_____

Subscriber _____

Subscriber DOB_____ Effective date_____

Siblings

Name _____ Age_____ DOB_____ Sex _____

Name _____ Age_____ DOB_____ Sex _____

Name _____ Age_____ DOB_____ Sex _____

We ask all patients to show their insurance cards and driver's license so that we may make copies of them. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, we will prepare and submit claim forms, reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION

I,_____, authorize **Quakertown Pediatrics** to furnish information concerning my child's office visits. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photocopy of this authorization will be as valid as the original. Co - pays are due on the date of the visit, a billing fee will be charged when co - pays are not paid on the same day.

Signature of Responsible Party_____ Date _____