Danville Pediatrics and Primary Care

PRIMARY INSURANCE INFORMATION

(The receptionist will need to get a copy of your insurance card, please bring to each visit.)

Child's Insurance Company:* _____ **Insured's Name:*** _____

Policy ID #:* _____ **Group #:** _____

Ins Co. Address:* _____ **State:*** _____ **Zip:*** _____

Ins Co. Phone:* _____ **Effective Date of Insurance:*** _____

Insured's Birthdate:* _____ **Relationship to Patient:*** _____

SECONDARY INSURANCE INFORMATION

Child's Insurance Company:* _____ **Insured's Name:*** _____

Policy ID #:* _____ **Group #:*** _____

Ins Co. Address:* _____ **State:*** _____ **Zip:*** _____

Ins Co. Phone:* _____ **Effective Date of Insurance:*** _____

Insured's Birthdate:* _____ **Relationship to Patient:*** _____

At times circumstances may require that others such as babysitters, step-parents or grand- parents may need to bring my child or children in for treatment. Since immunizations require a signature, I give the following individuals consent to sign for immunizations. These individuals will not have the authority to sign for the release of medical records.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

The undersigned hereby authorizes and directs Danville Pediatrics and Primary Care to prepare and submit any and all insurance claim forms as shall be necessary for the undersigned to obtain coverage for services rendered by DPPC. The undersigned authorizes payment to be made directly to DPPC for the surgical and or medical benefits. This authorization and signature may be kept on file by DPPC for claims submitted from and after this date, unless this authorization is withdrawn in writing.

I understand that I am responsible for any amount not covered by my insurance.

Signature of Parent or Legal Guardian:* _____