Danville Pediatrics and Primary Care, PLLC, 303 South 4th Street, Danville, KY 40422

Please Complete All Information

Person Responsible for Bill: *(THIS IS THE PERSON WITH WHOM THE CHILD LIVES)*

Name:______________________________ SS#______________ Birthdate__________

Mailing Address:______________________________ Relationship to patient______________

Physical Address :______________________________

City:______________ St: Zip: Employer______________

Home Phone (______)______________ cell phone (______)______________ work phone (______)______________

EMERGENCY CONTACT (Someone outside the home who can be reached for getting information to you about your child)

Name ______________ Phone(______) Relationship to Pt______________

Childrens' names:

**Please use child's full name

Childrens' names	Birthdate	Sex (Please circle)	Social Security Number	Being Seen Today? (Please circle)
______________	___/___/___	M or F	______________	Y or N
______________	___/___/___	M or F	______________	Y or N
______________	___/___/___	M or F	______________	Y or N
______________	___/___/___	M or F	______________	Y or N

Dad's Info:

Does this person carry the health insurance? Yes or No Primary or Secondary

Name______________ Birthdate:______________ SS#______________

Address:______________ City:______________ State______ Zip______

Phone (____)______ Cell phone (____)______ Employer______________ Work Phone(____)______

Mom's Info:

Does this person carry the health insurance? Yes or No Primary or Secondary

Name______________ Birthdate:______________ SS#______________

Address:______________ City:______________ State______ Zip______

Phone (____)______ Cell phone (____)______ Employer______________ Work Phone(____)______

Insurance Information:

The Receptionist will need to copy your insurance and/or medical card at each visit

ALL CO-PAYMENTS AND DEDUCTIBLES ARE EXPECTED TO BE PAID AT THE TIME OF SERVICE

Child(rens) primary insurance:______________________________

Insured's Name:______________ Policy #______________ Group#______________ Employer______________

Ins. Co. address:______________________________ State______ Zip______ Phone______________

Insured's Birthdate:__________ Relationship to Patient______________ Effective date of Insurance ____/____/____

Child(rens) secondary insurance:______________________________

Insured's Name:______________ Policy #______________ Group#______________ Employer______________

Ins. Co. address:______________________________ State______ Zip______ Phone______________

Insured's Birthdate:__________ Relationship to Patient______________ Effective date of Insurance ____/____/____

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 Danville Pediatrics and Primary Care. The undersigned authorizes payment to be made directly to Danville Pediatrics and Primary Care for the surgical and/or medical benefits. This authorization and signature may be kept on file by Danville Pediatrics and Primary Care 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. A monthly service charge of 1 1/2% will be added to all accounts with balances 90 days past due.**

Signature______________________________ Date______________

PARENT/LEGAL GUARDIAN