PEDIATRIC ENDOCRINE ASSOCIATES, P.C.

PATIENT INSURANCE INFORMATION

Patient Name ______________________ Account # ____________

Father's Name ______________________ Birthdate ____________

Business Name ______________________ Bus. Phone ____________

Business Address ______________________

Home Phone (if different from patient) ____________ Social Security # ____________

Home Address (if different from patient) ______________________

Mother's Name ______________________ Birthdate ____________

Business Name ______________________ Bus. Phone ____________

Business Address ______________________

Home Phone (if different from patient) ____________ Social Security # ____________

Home Address (if different from patient) ______________________

Primary Insurance (Mother ________ Father ________)

Policy Name ____________ Group # ________ ID # ________

Insurance Address ______________________

City ____________ State ______ Zip ________ Phone (   ) ____________

Secondary Insurance (Mother ________ Father ________)

Policy Name ____________ Group # ________ ID # ________

Insurance Address ______________________

City ____________ State ______ Zip ________ Phone (   ) ____________

Other Insurance:

RELEASE OF INFORMATION/AUTHORIZATION OF BENEFITS

I hereby authorize Pediatric Endocrine Associates, P.C. and its physicians to obtain and release past, present, and future medical records and information to or from other professional and insurance services to assist in my (child's) medical care and treatment. I do also permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time by notice in writing.

Date ____________ Signature ______________________

Relationship if not patient ______________________

I authorize payment of medical benefits to Pediatric Endocrine Associates, P.C. and its physicians for services rendered.

Date ____________ Signature ______________________

Relationship if not patient ______________________