BRUCE R.MADDERN, M.D., P.A.

A Division of Florida Pediatric Associates, LLC

PATIENT INFORMATION

Patient Name: ________________________________ DOB: ____/____/____ SS#: ______-_____-______

Address: ____________________________________ Apt#: _________ Phone#: (_____) ______-_________

City: _______________________State: ______Zip: __________ Sex: Male ___ Female ___

Referring Physician: ___________________________________Referring Physician phone#: (_____) ______-__________

Pharmacy :____ Pharmacy Phone: (_____) _______-_________________

Who has legal Custody of the Patient: ( )Parents ( )Mother Only ( ) Father Only ( ) Foster Parent ( ) Grandparent ( ) HRS/Other

****IF NOT BIOLOGICAL/NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT****

Mother's name: ____________________________________

SS#: ______-_____-______ DOB: ____/____/____

Address: ____________________________________
(if different from child's)

City: ________________State: ______Zip: _____________

Home #: (_____)_____-_______ Cell#: (_____)_____-_______

Work #: (_____)_____-_______ Employer: _________________

Father's name: ____________________________________

SS#: ______-_____-______ DOB: ____/____/____

Address: ____________________________________
(if different from child's)

City: ___________________State: ______Zip: __________

Home#: (____)______-______ Cell#: (____)_____-______

Work#: (____)_____-______ Employer_________________

Emergency Contacts

#1. Name: ______________________________ Relationship: ____________________ Phone#: (____) ____-_______

#2. Name: ______________________________ Relationship: ____________________ Phone#: (____) ____-_______

Insurance Information

Primary Insurance HMO PPO POS OTHER

Insurance Carrier: ______________________________

Policy#___________________________Group#__________

Policyholder's Name: ________________________________

Date of Birth_____________________________________

Relationship to patient:

Secondary Insurance HMO PPO POS OTHER

Insurance Carrier: ______________________________

Policy#__________________________Group#__________

Policyholder's Name: ______________________________

Date of Birth_____________________________________

Relationship to patient:

ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to Bruce R. Maddern, M.D., P.A., a division of Florida Pediatric Associates, LLC the surgical and/or medical benefits, if any, otherwise payable to me for services described on the attached claim, but not to exceed the charges for the service. If my health insurance plan will not direct payment to Bruce R. Maddern, M.D., P.A., I agree to forward all health insurance payments I receive for the services rendered by Bruce R. Maddern, M.D., P.A. a division of Florida Pediatric Associates, LLC upon receipt of such payments.

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Parent/Guardian Signature_______________________________________**Date**________________________