

Bruce R. Maddern, M.D.
A Division of Florida Pediatric Associates, LLC

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/____ SS#: ____-____-____ Sex: Male ___ Female ___
Address: _____ City: _____ State: _____ Zip: _____ Phone#: (____) _____
Race: African American Asian Caucasian Chinese Filipino Hispanic Japanese Native American Native Hawaiian
 Pacific Islander Other
Other family members treated here: _____
Primary Care Physician: _____ Phone#: (____) _____-_____
Pharmacy: _____ Pharmacy Phone: (____) _____-_____
Email: _____

PARENT(S) / LEGAL GUARDIAN INFORMATION

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: _____ DOB: ____/____/____ SS#: ____-____-____
Address: Check here if same as above

City: _____ State: _____ Zip: _____
Home #: (____) _____-____ Cell#: (____) _____-____ Work #: (____) _____-____
Occupation: _____ Employer _____ Employer Address _____

Father's name: _____ DOB: ____/____/____ SS#: ____-____-____
Address: Check here if same as above

City: _____ State: _____ Zip: _____
Occupation: _____ Employer _____ Employer Address _____
Home #: (____) _____-____ Cell#: (____) _____-____ Work #: (____) _____-____

EMERGENCY CONTACTS

#1. Name: _____ Relationship: _____ Phone#: (____) _____-____
#2. Name: _____ Relationship: _____ Phone#: (____) _____-____

INSURANCE INFORMATION

Insurance Carrier: _____ Policy# _____ Group# _____
Policyholder's Name: _____ Date of Birth _____ Relationship to patient: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Eligibility Phone# (____) _____-____ Co-Payment: \$ _____ Deductible: \$ _____
Insurance Carrier: _____ Policy# _____ Group# _____
Policyholder's Name: _____ Date of Birth _____ Relationship to patient: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Eligibility Phone# (____) _____-____ Co-Payment: \$ _____ Deductible: \$ _____

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

Parent/Guardian Signature _____ Date _____