Forest Pediatrics New Patient Form

Patient's Name(First, Middle Initial, Last)	**Emergency Contact other than Parents:**
Patient's Address	**Name:** _____ **Phone:**_____
City **State** **Zip**	**Referring Physician:** _____
Date of Birth **Gender**	Where did you find out about our Practice?
Brothers/Sisters Name **DOB** **Gender**	**Insurance Company** _____
	Primary Insured Name_____
	ID# _____

Mothers Name	**Father's Name**
Address	**Address**
City **State** **Zip**	**City** **State** **Zip**
Telephone **Date of Birth**	**Telephone** **Date of Birth**
SS#	**SS#**
Cell #	**Cell#**
Email Address	**Email Address**
Mother's Employer	**Father's Employer**
Address	**Address**
City **State** **Zip**	**City** **State** **Zip**
Work Tel#	**Work Tel#**
I authorize Forest Pediatrics, PA to provide pertinent records to any insurance company. x_____	I authorize Forest Pediatrics, PA to provide pertinent records to any insurance company. x_____

Thank you for choosing Forest Pediatrics, PA to provide your child with the highest quality care. The following is a statement of financial policy, which we require you to read and sign prior to initial treatment.

Patients with insurance: All Co-payments are payable at time of service. A $10.00 administrative charge will apply for non-payment on day of service. There is a $50.00 charge for missed appointments unless cancelled with 24 hr notice.
Patients without insurance: Full payment is due at time of service. We accept cash, checks, credit/debit cards. We do not accept American Express. A $30.00 fee will be imposed for any returned checks/credit/debit card payments.

As a courtesy we will bill your insurance carrier. If payment is not received within 60 days the "Responsible Party" will be billed the outstanding balance. Please let us know in advance if you have any questions about our policy.

I acknowledge that I have provided the above information correctly and accept responsibility for any outstanding balance due.

Signature:_____ Date_____