Pediatric Associates of Lafayette

Your information for us

Primary Physician *(Circle one)*: **PADGETT BELL THOMAS OTHER**

Child's Name _____ Sex _____ DOB _____
Last First Middle

Child's Name _____ Sex _____ DOB _____
Last First Middle

Child's Name _____ Sex _____ DOB _____
Last First Middle

Child's Name _____ Sex _____ DOB _____
Last First Middle

Child's Name _____ Sex _____ DOB _____
Last First Middle

Address _____
Street No. & Name Box No. City State Zip Code

Primary Phone (_____)_____ cell home *(must have cell as primary if opt for text message)*

RESPONSIBLE PARTY INFORMATION

Mother's Name _____ Marital Status _____
Last First Middle

Address *(if different from child)* _____ Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____

Date of Birth _____ Social Security No. _____

Employer _____ Work Phone (_____) _____

Father's Name _____ Marital Status _____
Last First Middle

Address *(if different from child)* _____ Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____

Date of Birth _____ Social Security No. _____

Employer _____ Work Phone (_____) _____

Primary Insurance Company Name _____ ID No. _____

Group or ID No. _____ Policy Holder _____ Policy Holder's DOB _____

Secondary Insurance Company Name _____ ID No. _____

Group or ID No. _____ Policy Holder _____ Policy Holder's DOB _____

OTHERS WHO MAY BRING CHILD & RECEIVE INFORMATION

Name _____ Relationship _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

I request and consent to the staff of Pediatric Associates of Lafayette, P.C. to provide medical care, tests, procedures and other services and supplies to my child as are considered necessary by my physician, whether accompanied by me or my designee. I authorize Pediatric Associates of Lafayette, P.C. to file claims to my insurance company and to provide information to the insurance carrier for the processing of claims for medical benefits. I request that my insurance company honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

I agree to be responsible for charges for all services and supplies rendered in this office. Pediatric Associates of Lafayette, P.C. will assist me in obtaining insurance benefits when those benefits are assigned to my physician. It is my responsibility to make sure insurance payments are processed and paid promptly to my physician. I understand that if I default on my account, I will be responsible for any pre-judgement and/or post-judgement interest at current legal rate, court costs, collection agency fees and attorney fees. I understand that you may contact me by telephone at any number associated with my account, including wireless telephone numbers. Methods of contact may include pre-recorded/artificial voice messages and/or the use of an automatic dialing device.

2020

_____ _____
Signature of Parent / Legal Guardian Date