Pediatric Health Associates, P.C.

576 Farmington Ave. Suite 2W
Hartford, CT 06105
Phone: (860) 266-4477 Fax: (860) 270-0616

Patient Information

Last:_____ **First:**_____ **Middle:**_____

D.O.B:_____ **Social Security:**_____ **Sex:**_____

Home Address:_____ **Phone:**_____

City:_____ **State:**_____ **Zip-code:**_____

Email:_____

Parent/Guardian Information

Name:_____ **Relationship:**_____

Home:_____ **Cell:**_____ **Work:**_____

Employer:_____

Insurance Information

Primary Insurance:_____

Guarantor:_____ **D.O.B:**_____

Policy #:_____ **Group #:**_____

Secondary Insurance:_____

Policy #:_____ **Group #:**_____

Guarantor:_____ **D.O.B:**_____

INSURANCE IS FILED BY THIS OFFICE AS A COURTESY TO THE PATIENT. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS THE PARENTS RESPONSIBILITY TO BE AWARE OF BENEFITS THAT THEIR INSURANCE PROVIDES FOR WELL CHILD CARE AND SICK VISITS. ALL INSURANCE CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

I hereby authorize Pediatric Health Associates, P.C. To furnish information to insurance carriers concerning my child's health and for treatment and hereby authorize assign to the physician all payment for medical services rendered to my dependents. I understand I am responsible for any amount not covered by insurance.

Signature:_____ **Date:**_____