A/C _____

# DUNDALK PEDIATRIC ASSOCIATES, P.A.

2112 Dundalk Avenue
Dundalk, Maryland 21222
410-284-1133

## PATIENT'S INFORMATION

| PATIENT NAME: First | Middle | Last | SOCIAL SEC # | M ☐ F ☐ | DATE OF BIRTH | AGE |
|---|---|---|---|---|---|---|
| | | | | | | |

| HOME ADDRESS | APT. NO. | CITY |
|---|---|---|
| | | |

| STATE | ZIP | HOME PHONE |
|---|---|---|
| | | |

HAVE ANY OF YOUR CHILDREN BEEN SEEN IN THIS OFFICE?
☐ Yes ☐ No LIST THEIR NAMES

| NAME | DATE OF BIRTH | NAME | DATE OF BIRTH |
|---|---|---|---|
| | | | |

## PARENT OR GUARDIAN Relationship _____

| FIRST | MI | LAST | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| HOME ADDRESS | APT NO. | CITY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

| EMPLOYER | WORK PHONE | CELL PHONE |
|---|---|---|
| | | |

| HOME PHONE | EMAIL |
|---|---|
| | |

## PARENT OR GUARDIAN Relationship _____

| FIRST | MI | LAST | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| HOME ADDRESS | APT NO. | CITY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

| EMPLOYER | WORK PHONE | CELL PHONE |
|---|---|---|
| | | |

| HOME PHONE | EMAIL |
|---|---|
| | |

## BILLING INFORMATION

| FINANCIALLY RESPONSIBLE PERSON<br>☐ Patient ☐ Father ☐ Mother ☐ Other _____ | NAME IF DIFFERENT FROM MOTHER OR FATHER | HOME PHONE |
|---|---|---|
| | | |

| FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (IF DIFFERENT FROM PATIENT) |
|---|
| |

| FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER | EMPLOYER ADDRESS | WORK PHONE |
|---|---|---|
| | | |

## INSURANCE INFORMATION

| POLICY HOLDER<br>☐ Patient ☐ Father ☐ Mother ☐ Other | PRIMARY INSURANCE COMPANY NAME | SUBSCRIBER'S NAME AND | DATE OF BIRTH<br>/ / |
|---|---|---|---|
| | | | |

| INSURANCE CO. ADDRESS | ID/POLICY NO. | GROUP NO. |
|---|---|---|
| | | |

## PREFERRED METHOD OF CONTACT ☐ PHONE ☐ EMAIL

## Co-Payments Due at Check-In

***THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED***

***Balances 60 days old will be turned over to a Collection Agency.***

I,_____,hereby authorize Dundalk Pediatric Associates to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to the physician in charge of my care. I authorize release of the necessary medical information.

_____ _____/_____/_____
Signature of Subscriber or Beneficiary Date

*SEE OTHER SIDE*

Dear Patient:

New Federal Health Care Regulations require Dundalk Pediatrics to ask for the following information about the **patient**. Please check the box that **best** describes the patient.
If you are not comfortable answering these questions, please indicate "refused".
Thank you for your cooperation.

**Race:**

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ More than one race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White
- ☐ Other _____

**Ethnicity:**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other _____

**Language:**

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Greek
- ☐ Other: _____
- ☐ Hebrew
- ☐ Japanese
- ☐ Arabic
- ☐ Hindi