Jackson Pediatric Associates

Patient Information

Patient Name	Gender	Date of Birth	Ethic Group
	M F		Caucasian Black Asian Hispanic Other
	M F		Caucasian Black Asian Hispanic Other
	M F		Caucasian Black Asian Hispanic Other
	M F		Caucasian Black Asian Hispanic Other

Father's Name ______________________ Date of Birth ______________

Address ______________________ City ______________ Zip Code ________

Social Security Number ______________________ Home Phone ______________

Place of Employment ______________________ Work Phone ______________

Permission to contact you at work? Yes No Cell Phone ______________

Email Address ______________________

Mother's Name ______________________ Date of Birth ______________

Address ______________________ City ______________ Zip Code ________

Social Security Number ______________________ Home Phone ______________

Place of Employment ______________________ Work Phone ______________

Permission to contact you at work? Yes No Cell Phone ______________

Email Address ______________________

Language(s) Spoken: English Spanish Japanese Sign Language Other ______________

Please Note- If addresses are not the same, where do the children reside:

Mom Dad Other ______________

Insurance Information

Primary Insurance ______________________

Policyholder Name ______________________ Date of Birth ______________

Contract # ______________________ Group # ______________

Secondary Insurance ______________________

Policyholder Name ______________________ Date of Birth ______________

Contract # ______________________ Group # ______________

Emergency Contact

Name & phone number of person to contact if you cannot be reached:

Name ______________________ Relationship ______________

Phone ______________________ Cell Phone ______________

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Jackson Pediatric Associates for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed ______________________ Date ______________

Relationship to the patient ______________________