JACKSON PEDIATRIC ASSOCIATES, P.A.
PATIENT DATA FORM

Patient First Name: _____ Middle: _____ Last: _____ Sex: M / F

Child's SSN: _____ Date of Birth: _____ Race: _____

Address: _____ City: _____ State: _____ Zip_____

Primary Insurance: _____ Policyholder's Name: _____

Relationship to patient: _____ Policyholder's Date of Birth: _____

Policy #:_____ Group #:_____

Secondary Insurance: _____Policyholder's Name: _____

Relationship to patient: _____ Policyholder's Date of Birth: _____

Policy #:_____Group #:_____

PARENT/GUARDIAN INFORMATION

Father's Name: _____ Date of Birth: _____ SSN #:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work: _____ Cell#:_____

Mother's Name: _____ Date of Birth: _____ SSN #:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work: _____ Cell#:_____

PERSON RESPONSIBLE FOR BILL

Name: _____ Relationship to Patient: _____

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES FOR HEALTHCARE SERVICES AND MATERIALS NOT COVERED BY MY HEALTH BENEFIT PLAN, UNLESS PROHIBITED BY LAW, OR THE TREATING PHYSICIAN OR GROUP PRACTICE HAS A CONTRACTUAL AGREEMENT WITH MY PLAN PROHIBITING ALL OR A PORTION OF SUCH CHARGES. I UNDERSTAND THAT IF I HAVE INSURANCE THROUGH ONE OF THE PARTICIPATING INSURANCE COMPANIES, THE COPAYS, DEDUCTIBLES, AND COINSURANCES ARE DUE IN FULL AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE APPOINTMENT.

I UNDERSTAND THE ABOVE TERMS OF PAYMENT _____
(SIGNATURE OF PERSON RESPONSIBLE)

OTHER INFORMATION: For emergency, list two relatives or friends not living with patient.

Name: _____ Relationship to Patient: _____ Phone #:_____

Name: _____ Relationship to Patient: _____ Phone #:_____

Email address (for appointment reminders) _____

Preferred # for appointment reminders text/call _____

Signature of Parent/Legal Representative: _____ Date: _____