Pediatric Associates of Lewiston P.A.

Patient Information

Patient Name:	**Date of Birth**:
Address:	
City, State, Zip:	
Home Phone:	
Ethnicity: Hispanic/Latino or Non Hispanic/Latino	**Race:**

Mother / Legal Guardian Information

Mother's Name:	**Date of Birth:**
Address:	**SSN:**
City, State, Zip:	
Home Phone:	**Cell Phone:**
Employer:	**Work Phone:**
E-mail Address: **(For future appointment reminders and statements)**	

Father / Legal Guardian Information

Father's Name:	**Date of Birth:**
Address:	**SSN:**
City, State, Zip:	
Home Phone:	**Cell Phone:**
Employer:	**Work Phone:**
E-mail Address: **(For future appointment reminders and statements)**	

Insurance Information

Primary Insurance:	
Address:	
City, State, Zip:	
Certificate #:	Group #:
Subscriber:	

Secondary Insurance:	
Address:	
City, State, Zip:	
Certificate:	Group #:
Subscriber:	

1. I certify that to the best of my knowledge the above information is correct.
2. I authorize Pediatric Associates of Lewiston P.A. to review my insurance coverage and to release any information pertinent to the processing of claims for services rendered to me.
3. I permit a copy of this authorization to be used in place of the original.
4. I hereby authorize you to pay directly to Pediatric Associates of Lewiston, P.A. benefits due to me out of my indemnity under the terms of my policy issued by your company.
5. I authorize Pediatric Associates of Lewiston, P.A. to release copies of my medical records to other medical providers who I maybe referred to, to further my care.

Signature of Guardian: _____ Print Name: _____

Date: 09/07/12