Health Insurance

1) Company Name ____________________

☐ Primary Insurance

ID #, SS # or Policy #: ____________________

Group # ____________________

Subscribers Name: ____________________

Subscriber's Date of Birth: ____________________

2) Company Name ____________________

☐ Secondary Insurance

Agreement or Policy #: ____________________

Group # ____________________

Policy Name: ____________________

Subscriber's Date of Birth: ____________________

Siblings

1. ____________________ Age: __________ Health: ____________________
2. ____________________ Age: __________ Health: ____________________
3. ____________________ Age: __________ Health: ____________________
4. ____________________ Age: __________ Health: ____________________
5. ____________________ Age: __________ Health: ____________________

I certify that the information provided is true and correct. I authorize the payment for services rendered should be made payable to Legacy Pediatrics. I authorize release of medical information necessary to process any claims. I understand that I am financially responsible to all charges not paid by insurance. I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

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Parent/Legal Guardian Signature Date

Referred by? ____________________

How did you hear about us? ____________________

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