

**BARRINGTON PEDIATRICS ASSOCIATES, INC**

PATIENTS NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ ALTERNATE/CELL \_\_\_\_\_

**PARENT GUARDIAN INFORMATION;**

FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_  
IF DIFFERENT FROM ABOVE IF DIFFERENT FROM ABOVE

EMPLOYER \_\_\_\_\_ EMPLOYER \_\_\_\_\_

WORK NUMBER \_\_\_\_\_ WORK NUMBER \_\_\_\_\_

**\*INSURANCE INFORMATION:**

CARDHOLDERS NAME \_\_\_\_\_ DOB \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ CO PAY \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

SECONDARY INSURANCE (IF ANY) \_\_\_\_\_

CARDHOLDERS NAME \_\_\_\_\_ DOB \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

PREVIOUS PHYSICIAN \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_

SIBLINGS \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

PATIENT ALLERGIES \_\_\_\_\_

\*  
I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER  
TO ME OR ON MY BEHALF TO BARRINGTON PEDIATRICS FOR ANY SERVICES  
RENDERED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION TO RELEASE  
ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR  
RELATED SERVICES.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_ DATE \_\_\_\_\_

