NAVARRE PEDIATRICS

Patient Information

PATIENT INFORMATION : THIS SECTION REFERS TO THE PATIENT ONLY		
Name:		
Date of birth:		Phone:
Current address:		
City:	State:	ZIP Code:
Parent Email address :		
Sibling Names :		
Gender : Male Female	**PLEASE CIRCLE ONE** Race: American Indian/Alaska Native/Asian/Black/African American/Native Hawaiian/White/More than one race/Unreported/Refused to Report	**PLEASE CIRCLE ONE** Ethnicity: Hispanic/Latino/Non Hispanic/Unreported/Refused to Report Race and Identity

PARENT AND GUARDIAN INFORMATION		
Father's Name		
Address:		
City: State:		ZIP Code:
Phone:	SSN	DOB
Mother's Name		
Address		ZIP Code:
City: State:		
Phone:	SSN	DOB

This section refers to the PERSON WHOSE NAME IS LISTED ON THE INSURANCE CARD

SUBSCRIBER INFORMATION		
Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Current employer:		
Phone:		

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN	
I hereby authorize the office of NAVARRE PEDIATRICS PL to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This include, but is not limited to, coinsurance, co-payment, deductible and non-covered services.	
X	**Date**

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