HAPPY AND HEALTHY PEDIATRICS, P.A.

PLEASE COMPLETE THIS FORM. DO NOT LEAVE ANY BLANK SPACES.

*******CANCELLATION POLICY*******

Please be aware if you do not call to cancel before your appointment time there will be a $20 fee per child.

CHILDREN:

FIRST & LAST NAME_____ DOB:_____ M or F (please circle one)

FIRST & LAST NAME_____ DOB:_____ M or F (please circle one)

FIRST & LAST NAME_____ DOB:_____ M or F (please circle one)

FIRST & LAST NAME_____ DOB:_____ M or F (please circle one)

FIRST & LAST NAME_____ DOB:_____ M or F (please circle one)

PHARMACY NAME:_____ PHARMACY PHONE #:_____

MOTHER:	**FATHER:**
Name:	Name:
Address: Apt.	Address: Apt.
City: State: Zip:	City: State: Zip:
Cell Phone:	Cell Phone:
Home/Work Phone:	Home/Work Phone:
Email:	Email:
S.S.# Only if your Insurance is Tricare or requires us to file a claim	S.S.# Only if your Insurance is Tricare or requires us to file a claim
Date of Birth:	Date of Birth:
Occupation:	Occupation:
Employer Name:	Employer Name:

INSURANCE COMPANY NAME:_____
NAME OF INSURED:_____
MEMBER ID:_____ GROUP ID:_____
MAILING ADDRESS FOR CLAIMS:_____
PHONE NUMBER OF INSURANCE COMPANY:_____

EMERGENCY CONTACT (other than parent):_____
RELATIONSHIP:_____
PHONE NUMBER:_____

Assignment of benefit: I hereby authorize the release of any medical information necessary to process an insurance claim and assign payment to be made directly to HAPPY AND HEALTHY PEDIATRICS, P.A. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges regardless of my insurance claims.

Parent/Guardian Signature:_____ Date:_____