# PEDIATRIC INSURANCE/BILLING DATABASE

*Please help us serve you well by listing as much information as possible!*

**Patient Name** _____ DOB _____

**Primary Insurance** _____

Insured Party Name _____

Insured Party DOB _____ Insured Party SSN _____

**Secondary Insurance** _____

Insured Party Name _____

Insured Party DOB _____ Insured Party SSN _____

**Additional Coverages** _____

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**I understand that it is my responsibility to provide current and accurate information about my child's insurance coverage at each visit. I understand that whoever brings my child to the office is responsible for making co-payments at the time of the visit as required by my insurance, and that it is my own responsibility to reimburse, or seek reimbursement from, third parties who may bring my child for examination if I am not present myself. I understand that I am responsible for the entire cost of care if my insurance is not current or has been discontinued for any reason, or if inaccurate information is given at the visit.**

Signature _____ Date _____

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*For Office Use Only*

*Reviewed:*

Date_____ Initials _____ Date_____ Initials _____ Date_____ Initials _____

Date_____ Initials _____ Date_____ Initials _____ Date_____ Initials _____