Kids First Pediatrics, PC

Insurance Form

PJ WR

Patient Name: ____________________ **Birth Date:** __________

Gender: M F

New Insurance ID # ____________________

Primary Care Physician: ________

Siblings:

*Sibling # **1** Name:* ____________________ *Birth Date:* __________

Gender: *M F* *New Insurance ID #* ______________ *PCP:* ______

*Sibling # **2** Name:* ____________________ *Birth Date:* __________

Gender: *M F* *New Insurance ID #* ______________ *PCP:* ______

Insurance Information:

Ins. Company: ____________________ Effective Date: __________

Primary Subscriber (Policy Holder) ID# ____________________

Name: ____________________ Birth date: __________

SS#: ____________________

SECONDARY Insurance Coverage? (Please Circle) Y N

Secondary Insurance Information: *Patient's ID#* ______________

Ins. Company: ____________________ *Effective Date:* ______

Secondary Insurance (Policy Holder) ID# ____________________

Name: ____________________ *Birth date:* ______________

Although covered by insurance, I am aware that I am personally responsible for all charges incurred if the following information is erroneous including but not limited to effective dates, PCP selection and covered benefits.

______________________________ ______________

Parent's Signature **Date**

Check In _____ Card Scanned _____ Verified PCP _____ Updated _____ Billing _____