



Pediatric Patient Information (Ages 0-17)

Patient Information:

Last Name _____ First _____ MI _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Sex _____ Primary Language _____

Preferred Local Pharmacy _____ Phone _____

Mail Order Pharmacy _____ Fax _____

Parental Information:

Mother _____ Father _____

SS# _____ SS# _____

DOB _____ DOB _____

Address _____ Address _____

Home Tel. # _____ Home Tel. # _____

Work Tel. # _____ Work Tel. # _____

Cell Tel. # _____ Cell Tel. # _____

Employer _____ Employer _____

Legal Guardian _____ Relationship _____ Phone _____

Legal Guardian Address _____

Emergency Contact _____ Relationship _____ Phone _____

Emergency Contact Address _____

Billing Information:

Responsible Party _____ Relationship _____ Phone _____
(Person financially responsible for services rendered)

Responsible Party Address *(if different from above)*

Primary Insurance Co _____ ID Number _____

Cardholder's Name _____ Group Number _____

Secondary Insurance Co _____ ID Number _____

Cardholder's Name _____ Group Number _____

I hereby assign all payments for medical services provided to myself or my dependents to Paramount Medical Group. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE _____ DATE _____