First_____Middle_____Last Name_____

Social Security Number_____Birthdate_____Sex M_____ F_____

Address_____
Street City State Zip
Home Phone ( )_____ Other ( ) _____

Father's Name_____
DOB_____SS#_____
Address_____
_____
Home #_____
Cell #_____
Email_____
Work #_____Ext._____

Mother's Name_____
DOB_____SS#_____
Address_____
_____
Home #_____
Cell #_____
Email_____
Work #_____Ext._____

Other Contact Info

Emergency Contact Name_____Relationship_____
Emergency Home #_____ Other # for Emerg. Contact_____
Previous M.D. or Referral Source_____

Insurance Information

Responsible Party
Name_____
Insurance Co. Name_____
Member ID #_____
Group#_____Effective Date_____
Employer_____
Claims Address_____
City_____State____Zip_____
Insurance Co Phone#_____

Insured (If different from Responsible Party)
Name_____
DOB_____Relationship _____
Address_____
_____
City_____State_____Zip_____

RESPONSIBLE PARTY STATEMENT: I hereby authorize Excel Pediatrics to furnish information to insurance carriers concerning my child/ children's illness(es) and treatment(s). I understand that I am financially responsible for all charges whether or not covered by insurance and that unless I am a member of an organization with which Excel Pediatrics is a contracted provider, all charges are due at the time the service is rendered.
GUARANTOR SIGNATURE:_____
The next set of questions are for reporting purposes only, you may refuse to answer.

Race

[] American Indian or Native Alaskan
[] Asian
[] Black or African/ American
[] Native Hawaiian/ Other
[] White
[] Refusal to report/ Unable to Report

Ethnicity

[] Hispanic/Latino
[] Non- Hispanic/ Non-Latino
[] Refuse to Report/ Unable to Report

What is the Primary Language you speak at home? _____