Rainbow Pediatrics

413.241.6152

Patient Information

Sex: F M

Last Name: _____First Name: _____DOB: _____
Street Address: _____
City: _____ State: _____Zip Code: _____
Resides With: Mother ( ) Father ( ) Both ( ) Legal Guardian ( ) Other ( ) _____
Soc. Security#:_____ School/Day Care: _____

Parents Information

Mother's Name: _____Father's Name: _____
DOB: ___ / ___ / ____ DOB: ___ / ___ / ____
Address (if different from above): _____
City: _____ State: _____ Zip Code: _____
Phone#: _____ Phone#: _____
Responsible for bills (circle one): Yes No

Insurance Information

Primary Insurance Name: _____ Name on INS Card _____
Subscriber's#/ S.S #: _____ Date of Birth: _____ Group#: _____
Relationship to Patient: Self ( ) Spouse ( ) Child ( ) Other ( ) _____ Co-pay $: _____

In Case of Emergency

Name: _____ Relationship to Patient _____ Phone# _____
Name: _____ Relationship to Patient _____ Phone# _____

I hereby assign all medical and/or surgical benefits to include: Medicare, Medicaid and all Commercial insurance companies, to which I am entitled, including private insurance and other Health plans to: Rainbow Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE CARRIER. I Understand I will be terminated as patient if I have no-showed for my appointments more than 3 times. Rainbow will refuse to see me as a patient if I have a balance owed previously. I authorize use of this form for all my insurance submissions. I authorize release of information to my insurance company. I understand that I am responsible for obtaining any referrals that are needed .I understand that I have to pay the balance in full within 30 days of receipt of my statement from Rainbow Pediatrics. I understand that I will be terminated as a patient, if the balance is not paid in full. I understand that if I transfer out of the practice or am terminated I will have to pay a $25 fee for records and the balance owed before any records are released. I understand that there will be an $8 charge for each additional annual physical form I request.

Signature: _____ **Date:** _____