## *Pediatric Partners, LLC*

Demographic and Insurance Verification Form

**Please Update/Correct information in the column on the Right**

| **DEMOGRAPHIC INFORMATION** | **UPDATES / CORRECTIONS** |
|---|---|
| Patient Name: | |
| Mailing Address: | |
| Home Phone: | |
| Cell Phone: | |
| Work Phone: | |
| OK to Leave Message: | **□ Home □Work** |
| Primary Care Physician (PCP): | |
| Date of Birth: | |
| Sex: | |
| Race: White___ Black ____ Hispanic_____ Other: _____ | Ethnicity: □ Hispanic □ Non-Hispanic |
| Sibling: | |
| Sibling: | |
| E-mail: | |
| | |
| **EMERGENCY CONTACT INFORMATION (OUT OF HOUSEHOLD)** | **UPDATES / CORRECTIONS** |
| Emergency Contact Name: | |
| Phone Number: | |
| Relationship to Patient: | |
| | |
| **GUARANTOR/RESPONSIBLE PARTY** | **UPDATES / CORRECTIONS** |
| Name: | |
| Guarantor Address (Billing Address): | |
| | |
| **PRIMARY INSURANCE INFORMATION** | **UPDATES / CORRECTIONS** |
| Insurance: | |
| Insured's Name: | |
| Insured's Date of Birth: | |
| Subscriber Number: | |
| Group Number: | |
| Employer Name: | |
| | |
| **SECONDARY INSURANCE INFORMATION** | **UPDATES / CORRECTIONS** |
| Insurance: | |
| Insured's Name: | |
| Insured's Date of Birth: | |
| Subscriber Number: | |
| Group Number: | |
| Employer Name: | |
| | |
| **PHARMACY INFORMATION** | **UPDATES / CORRECTIONS** |
| Pharmacy Name/Location: | |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Pediatric Partners LLC. I understand that I am financially responsible for any balance unpaid. I also authorize Pediatric Partners LLC to release any information required to process my claims.

**DATE** _____

**Parent/Guardian Signature**

**Relationship To Child**