WILMINGTON HEALTH ASSOCIATES

Pediatric Patient Information (Patient less than 18 years old)

Account No. _____

Doctor's No. _____

PLEASE ANSWER ALL QUESTIONS

NAME: LAST _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SS# _____

HOME PHONE _____

CELL PHONE _____

SEX ☐M ☐F

RACE ☐White ☐Black/African American ☐American Indian/Alaska Native ☐Native Hawaiian or Pacific Islander

ETHNIC ORIGIN ☐Asian ☐Hispanic ☐Other ☐Non-Hispanic ☐Unknown

ADDRESS _____ ADDRESS 2 _____

CITY _____ STATE _____

ZIP CODE _____ 4 DIGIT _____ COUNTY _____

COUNTRY _____ MARITAL STATUS _____

EMPLOYER _____ ADDRESS _____

WORK PHONE _____ EXT _____ PRIMARY CARE DOCTOR _____

RESPONSIBLE PARTY

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____

EMPLOYER _____ RELATIONSHIP _____ MARITAL STATUS _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

MOTHER

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____

EMPLOYER _____ MARITAL STATUS _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

FATHER

NAME _____ BIRTHDATE _____ HOME PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____

EMPLOYER _____ MARITAL STATUS _____ SEX _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

INSURANCE INFORMATION

1) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

2) INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MEDICARE/ID# _____

GROUP # _____

POLICY HOLDER INFO

NAME _____

RELATIONSHIP TO PATIENT _____

SS# _____

DATE OF BIRTH _____

EMPLOYER _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) I authorize my insurance carrier to release information regarding my coverage to Wilmington Health Associates. I also authorize agents of any hospital, treatment center or previous physicians to furnish copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Wilmington Health Associates. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Wilmington Health Associates. This assignment covers any and all benefits under medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Wilmington Health Associates.

Patient Signature _____ Date/Time _____

Responsible Party Signature _____ Date/Time _____

A copy of this authorization and assignment shall be considered as valid as the original.