PEDIATRIC MEDICAL ASSOCIATES
Practice Limited To: Infants, Children, Adolescents

Visit us on our Website:
www.pmadocs.com

160 W. Germantown Pike · Suite D2 · East Norriton, PA 19401 · (610) 277-6400 · Fax (610)

Patient Name_____ **Sex**____ **D.O.B.**_____ **Birth Place**_____

_____ **Sex**____ **D.O.B.**_____ **Birth Place**_____

_____ **Sex**____ **D.O.B.**_____ **Birth Place**_____

Patient Address_____ **City**_____

State_____ **Zip Code**_____ **Phone Number**_____

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Please check the appropriate box for the card holder/ subscriber of insurance for the child(ren): ☐**Father** ☐**Mother**

Father's Name_____ **D.O.B.**_____ **SS#**_____

Father's Address (If different from above)_____

City/State_____ **Zip Code**_____ **Phone Number**_____

Employer_____ **Occupation**_____ **Work #**_____

Mother's Name_____ **D.O.B.**_____ **SS#**_____

Mother's Address (If different from above)_____

City/State_____ **Zip Code**_____ **Phone Number**_____

Employer_____ **Occupation**_____ **Work #**_____

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Relative/Friend (In Case of Emergency)_____ **Phone**_____

Preferred E-Mail Address (Father or Mother)_____

Cell Phone # (Father)_____ **(Mother)**_____

THE POLICY OF OUR OFFICE: THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES INCURRED. PAYMENT IS EXPECTED AT TIME OF SERVICE.

INSURED OR AUTHORIZED PERSON: I authorize the release of any medical information necessary to process all claims and I authorize payment of medical benefits to PEDIATRIC MEDICAL ASSOCIATES for services rendered.

Signature_____ **Date**_____

I HAVE BEEN MADE AWARE OF PMA'S NOTICE OF PRIVACY PRACTICES.

Signature_____ **Date**_____