

Darien Pediatric Associates, LLC

106 Noroton Ave, Darien, CT, 06820
Phone: (203) 655-9741 – Fax: (203) 655-9249

*** CURRENT INFORMATION SHEETS ARE REQUIRED YEARLY BY YOUR INSURANCE COMPANY ***									
CHILD(REN)'S INFORMATION									
NAMES SHOULD BE EXACTLY AS PRINTED ON INSURANCE CARD									
Name: (First) (MI) (Last)				Date of Birth:		Gender:		Insurance ID #:	
Name: (First) (MI) (Last)				Date of Birth:		Gender:		Insurance ID #:	
Name: (First) (MI) (Last)				Date of Birth:		Gender:		Insurance ID #:	
Name: (First) (MI) (Last)				Date of Birth:		Gender:		Insurance ID #:	
Name: (First) (MI) (Last)				Date of Birth:		Gender:		Insurance ID #:	
MOTHER'S INFORMATION									
Name: (First) (MI) (Last)				Date of Birth:		Marital Status:		Social Security #:	
Address:				City:				State:	Zip:
Home Phone:		Work Phone:		Cell Phone:		E-mail:		Employer/Occupation:	
FATHER'S INFORMATION									
Name: (First) (MI) (Last)				Date of Birth:		Marital Status:		Social Security #:	
Address:				City:				State:	Zip:
Home Phone:		Work Phone:		Cell Phone:		E-mail:		Employer/Occupation:	
EMERGENCY CONTACT INFORMATION – (SOMEONE OTHER THAN PARENTS)									
Name: (First) (MI) (Last)					Relationship To Child:				
Home Phone:			Work Phone:			Cell Phone:			
INSURANCE INFORMATION									
CARRIER OF INSURANCE: <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> OTHER (IF OTHER, PLEASE FILL IN BELOW)									
Insurance Company Name:					Identification # / Group #:			Effective Start Date:	
Subscriber Name:				Subscriber SS#:		Subscriber Date of Birth:		Relationship To Child:	
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES									
<input type="checkbox"/>	I hereby acknowledge that I received a copy of Darien Pediatrics Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and I may request a copy of any amended notices at each appointment.								
I AGREE TO THE ASSIGNMENT OR FINANCIAL RESPONSIBILITIES SHOWN BELOW AND HIPAA PRIVACY PRACTICES ABOVE									
I authorize Darien Pediatric Associates, LLC, to treat my child/children and the release of medical information as necessary for the completion of insurance, school and camp forms. I authorize payment directly to Darien Pediatric Associates, LLC, for any and all medical benefits payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am financially responsible for all co-payments, deductibles and any charges not covered under my insurance benefits. I also understand I am responsible for advising Darien Pediatric Associates, LLC, of any changes to my insurance. If I do not have insurance coverage, I understand I am responsible for payment in full. Payments of co-pays are due on the date of service. Failure to pay the co-payment at that time will result in an additional billing charge of \$5.00. I understand that 24 hours notification is required for cancelling any physical appointment; failure to do so will result in a \$50 cancellation fee. A \$20 fee will be charged for any other missed appointment. This assignment will remain in effect until revoked in writing.									
Signed (Adult Responsible for Payment):				Print Name:				Date:	