

MOORE PEDIATRICS AND ASSOCIATES

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NAME OF CHILDREN

_____ MIDDLE INITIAL _____ DOB: _____ M OR F

_____ MIDDLE INITIAL _____ DOB: _____ M OR F

_____ MIDDLE INITIAL _____ DOB: _____ M OR F

_____ MIDDLE INITIAL _____ DOB: _____ M OR F

FAMILY INFORMATION

MOTHER'S NAME _____ **DATE OF BIRTH** _____

HOME ADDRESS _____ **MARTIAL STATUS** S M D

CITY _____ **ZIP** _____

PHONE NUMBER- HOME _____

CELL _____

PLACE OF EMPLOYMENT _____ **WORK PHONE** _____

FATHER'S NAME _____ **DATE OF BIRTH** _____

HOME ADDRESS (IF DIFFERENT) _____

PHONE NUMBER - HOME _____

CELL _____

PLACE OF EMPLOYMENT _____ **WORK PHONE** _____

WHOM MAY WE THANK FOR REFERRING YOU TO MOORE PEDIATRICS? _____

E-MAIL: _____

MAY WE USE THIS E-MAIL ADDRESS FOR COMMUNICATION? _____

EMERGENCY NOTIFICATION

NAME _____ RELATIONSHIP _____

PHONE NUMBER _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY _____

INSURANCE ADDRESS _____

INSURANCE PHONE NUMBER _____

POLICYHOLDER _____ BIRTHDATE _____

POLICY NUMBER _____ GROUP NUMBER _____

POLICYHOLDER EMPLOYER _____

SECONDARY INSURANCE

INSURANCE COMPANY _____

INSURANCE ADDRESS _____

INSURANCE PHONE NUMBER _____

POLICYHOLDER _____ BIRTHDATE _____

POLICY NUMBER _____ GROUP NUMBER _____

POLICYHOLDER EMPLOYER _____

I authorize this office to release any information necessary to expedite insurance claims. I authorize payment of medical benefits to Moore Pediatrics & Associates. I understand that I am responsible for all charges, regardless of insurance coverage for non covered benefits or insurance companies that this office does not participate with.

I understand I will be responsible for all additional costs associated with my bill, if it is forwarded to a collection agency.

_____/_____/_____
Signature Date