



**PRIMARY INSURANCE**

Ins. Co. Name: \_\_\_\_\_ Effective Date: \_\_\_/\_\_\_/\_\_\_  
Policyholder Name: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_  
Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Group No: \_\_\_\_\_  
Policy/ID No: \_\_\_\_\_ Co-pay Amount: \$ \_\_\_\_\_ or \_\_\_\_\_ % of visit

**SECONDARY INSURANCE**

Ins. Co. Name: \_\_\_\_\_ Effective Date: \_\_\_/\_\_\_/\_\_\_  
Policyholder Name: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_  
Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Group No: \_\_\_\_\_  
Policy/ID No: \_\_\_\_\_ Co-pay Amount: \$ \_\_\_\_\_ or \_\_\_\_\_ % of visit

**ADDITIONAL INFORMATION**

Name of Male Step-parent (if applicable): \_\_\_\_\_  
Legal Male Guardian (if applicable): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Name of Female Step-parent (if applicable): \_\_\_\_\_  
Legal Female Guardian (if applicable): \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Whom to Call in Case of Emergency? (Other than parents)  
Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**SIGNATURE REQUIRED**

*I hereby authorize SUBURBAN PEDIATRIC ASSOCIATES, INC. (SPA) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by SPA health care providers and hereby direct my insurance carrier or its intermediaries to issue payment directly to Suburban Pediatric Associates, Inc. on behalf of such rendered services. I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. I further certify that I have received, read and agree with the SPA Privacy Policy document.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date