NEXT GENERATION PEDIATRICS
100 Technology Drive, Suite 2
Butler, Pa 16001
724-482-2220

Thank you for choosing our office! In order to serve you properly, please print the following information. All information on this form will be kept confidential.

Patient Information

Patient Name: _____ Today's Date: _____

Birth Date: _____ Sex: M F Home Phone: _____

Address: _____ City: _____ Zip: _____

Patient's Social Security Number: _____

Is the child known by any other names? _____

Ethnic Group: _____ Race: _____ Language: _____

Email: _____

Mother's Full Name: _____ Father's Full Name: _____

Responsible Party – (the person who will be paying the bill)

Name: _____ Relationship to the patient: _____

Address: _____ City: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Birth Date: _____ Social Security Number: _____

Occupation: _____ Employer: _____

Insurance Information

Name of Insured (Patient): _____ D.O.B. _____

Insurance Company: _____ ID: _____

Group: _____ Co-Pay: $_____

Secondary Insurance Name (if applicable): _____ ID: _____

Group: _____ Co-Pay: $_____

****please see reverse side for additional information****

Patient Information

Patient Name: _____ Birth Date: _____

Pharmacy Information

Current Pharmacy Name: _____

Pharmacy Location: _____ Pharmacy Phone: _____

Emergency Contacts (2 different contacts other than parent or person paying the bill)

Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone:_____Cell Phone: _____

Work Phone: _____

Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____

Please review and make any necessary changes on this form and have your insurance cards available for photocopying.

I understand release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

I understand that payment for all co-payments and non-covered services is expected at the time of service.

I understand that there will be a $25.00 billing fee for any co-payment and non-covered services that are not paid within 30 days and I also understand that an additional $25.00 billing fee will be added if a payment is not made within 60 days.

Patient or Guarantor (if minor) Signature: _____

Date: _____