Scarano & Taylor Pediatrics

PATIENT DEMOGRAPHICS

PLEASE COMPLETE ALL INFORMATION

Patient's Full Legal Name_____Sex_____
Date of Birth _____ Social Security # _____
Address (Where Patient Lives)_____
City _____ State____ Zip_____ Patient's Phone_____

Father_____	Mother_____
Birthdate_____	Birthdate _____
S.S.#_____	S.S.# _____
Address _____	Address_____
City _____	City _____
State____ Zip_____	State____ Zip_____
Home Phone_____	Home Phone_____
Cell Phone_____	Cell Phone_____
Employment_____	Employment_____
Work Phone_____	Work Phone_____
Best Contact Phone - Home/Cell/Work *(circle one)*	**Best Contact Phone** – Home/Cell/Work *(circle one)*

Emergency Contact (Other than Parent)_____
Their Phone_____
Daycare_____ Phone_____

Insurance Company Name_____Effective Date_____
Policy #_____Group#_____
Claim Address _____
Policy Holder Name_____Relationship_____
Policy Holder DOB_____Policy Holder SS#_____

Names/Birthdates of Other Children that have been seen here:
_____(DOB)_____ _____(DOB)_____
_____(DOB)_____ _____(DOB)_____

Statement of Insurance Assignment
I authorize the release of any medical of other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to Giangreco, Scarano & Taylor, P.A. for any services provided.

_____ _____
Signature of Parent or Legal Guardian Date

Parkwood Professional Center
4861 27th Street West
Bradenton, FL 34207
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www.gstpediatrics.org