Anthony P Moreschi M.D., P.C.
Pediatrics
811 S Isabella Street Ste. C
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Patient Information

Last Name	**First Name**	**Middle Name**	**Suffix** ☐None ☐Jr ☐Sr ☐I ☐II ☐III
Name child goes by	**Gender** ☐ M ☐ F	**SSN:**	**Date of Birth**
Race ☐Indian or Alaskan ☐ Asian ☐Black of African American ☐White ☐Other			
Current Address	**City**	**State**	**Zip Code**
Home Phone	**Cell Phone**	**Work Phone**	**E-mail**
Preferred Contact Method(s)			

Sibling Information (Use back of page for additional siblings)

Last Name	First Name	Middle Name	Date of Birth	Gender	SSN:
				M☐ F☐	
				M☐ F☐	

Patient's Primary Responsible Party Information

Last Name	**First Name**		**Middle Name**
Relationship to patient	**Date of Birth**	**SSN:**	**Marital Status** ☐Married ☐Single ☐Divorced ☐Separated
Home Phone	**Cell Phone**	**Work Phone**	
Current Address	**City**	**State**	**Zip Code**

Patient's Secondary Responsible Party Information

Last Name	**First Name**		**Middle Name**
Relationship to patient	**Date of Birth**	**SSN:**	**Marital Status** ☐Married ☐Single ☐Divorced ☐Separated
Home Phone	**Cell Phone**	**Work Phone**	
Current Address	**City**	**State**	**Zip Code**

Primary Medical Insurance Information (☐ Check here if you have no primary insurance)

Ins. Company	**Policy Holder**		**Policy Holder D.O.B**
Policy Number	**Group Number (if applicable)**	**Date effective (if known)**	**Relationship to patient**

Secondary Medical Insurance Information (☐ Check here if you have no secondary insurance)

Ins. Company	**Policy Holder**		**Policy Holder D.O.B**
Policy Number	**Group Number (if applicable)**	**Date effective (if known)**	**Relationship to patient**

Assignment of Benefits {} Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Anthony P Moreschi, M.D., P.C., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further afree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE: _____ **DATE:** _____