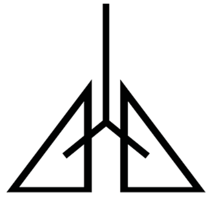

Pediatric Pulmonary Associates

Education. Trust. Availability. For **every** child.

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WELCOME TO OUR OFFICE! We ask that you fill out this form completely once a year, so that we have the most current information for contacting you, billing, processing your insurance forms and sending your prescriptions.

Patient Information:

Name: ______________________ DOB: ___/___/___ Sex: M F ______

Address: ______________ City: ______________ State: ______________ Zip: ______________

Mailing Address: ______________ City: ______________ State: ______________ Zip: ______________

Name of Pediatrician: ______________________ Phone Number: ______________________

Ethnicity/Race

- ○ American Indian or Alaska Native
- ○ Hispanic or Latino
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or other Pacific Islander
- ○ White
- ○ Decline to specify

Parental/Guardian Information

Name: ______________________ DOB: ___/___/___ Relationship to Patient: ______________

Address: ______________ City: ______________ State: ______________ Zip: ______________

Home Phone #: ______________ Cell Phone #: ______________ Work Phone # ______________

Email: ______________________

Primary Insurance Information

Insurance Company: ______________ Insurance Phone #: ______________ Cardholder SSN #: ______________

Cardholder Name: ______________ Policy #: ______________ Group#: ______________

Secondary Insurance Information

Insurance Company: ______________ Insurance Phone #: ______________ Cardholder SSN #: ______________

Cardholder Name: ______________ Policy #: ______________ Group#: ______________