

Pediatric Associates of Kingston, LLC
 425 Tioga Avenue Kingston, Pa 18704

Welcome to Pediatric Associates. We look forward to providing your pediatric services. To get started, we would appreciate you filling out this registration form.

Please let us know how you were referred to us: _____

Preferred E-Mail Address: _____

Mother's (or guardian)

Name: _____ DOB _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Social Security Number: _____

Employer: _____

Father's (or guardian)

Name: _____ DOB _____

Address: _____ Work: _____ Cell: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____

Employer: _____

Emergency Contact:

Name: _____

Phone Number: _____ Relationship: _____

Primary Insurance:

Subscriber Name: _____ Relationship: _____

Insurance Co. Name: _____

Member ID #: _____ Member Group # _____

Secondary Insurance:

Subscriber Name: _____ Relationship: _____

Insurance Co. Name: _____

Member ID #: _____ Member Group # _____

I grant permission for Pediatric Associates (PAK), their staff and associates, to provide medical care for my child (ren) and to provide insurance company (ies) any information which may be requested. I hereby assign PAK monies to which I am entitled for medical expenses relative to the service(s) rendered by them. I understand that I am fully responsible to the doctor for charges not covered by this assignment or for services not covered by my insurance(s). I authorize Pediatric Associates to release Protected Health Information and/or present my child for care to the following person(s) during my absence.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent Signature: _____ **Date:** _____

Please List Your Child (ren)'s Information Below

Name	Date of Birth	SSN (if available)