Altamonte Pediatric Associates

PRACTICE LIMITED TO INFANTS, CHILDREN AND ADOLESCENTS

Child's Information				
Date:	Patient's Full Name:		Sex:	Patient Number:
DOB:	Age:	Child lives with: □Both Parents □Mother □Father □Other (Specify)_____		
My child will primarily be seen at the: □Altamonte Office □Lake Mary Office □Apopka Office				
Preferred Provider (Select One Physician or Nurse Practitioner Below):				
□Dr. Soven □Dr. Harris □Dr. Belton □Dr. Candelori □Dr. Good □Dr. Nguyen				
□Janice Krivan □Angie Donahue □Kerry Mullen □Kristin Powell □Lisa Goddard □Allison Loft □Hebest Vuillier				

Race:	□Caucasian □Black/African American □Asian □Native American □Not Reported/Refuse □Other_____
Ethnicity:	□Latino/Hispanic □Not Latino/Hispanic □ Not Reported/Refuse
Language:	□English □Spanish □Other_____

Contact Information	
Best Number to Text You (Mobile):	
Email Address:	
Best Number to Call You (Home or Mobile):	

Caregiver Information	
Parent 1/Guarantor Information	Parent 2 Information
Full Name: DOB:	Full Name: DOB:
Address:	Address:
Phone Number: □Mobile □Home	Phone Number: □Mobile □Home
Parent's Marital Status: □Married □Single □Divorced □Widowed □Separated	

Primary Insurance	
Plan Name:	Subscriber Name:
Plan Telephone:	Subscriber DOB:
Group #:	Subscriber ID/Policy:
Relationship to Patient: □Self □Parent □Other (Specify)_____	

Secondary Insurance (Medicaid Only)	
Plan Name:	Subscriber Name:
Plan Telephone:	Subscriber DOB:
Group #:	Subscriber ID/Policy:

I authorize payment of medical benefits to Altamonte Pediatric Associates, P.A. for services rendered. I also authorize the release of any medical information necessary to process my insurance claim. I understand that it is my responsibility to notify Altamonte Pediatric Associates, P.A. of any changes in either primary or secondary insurance. I have read and understand the financial responsibility provided by Altamonte Pediatric Associates.

I hereby consent to receive autodialed and or pre-recorded calls, text messages, and emails from or on behalf of Altamonte Pediatric Associates, P.A. at the telephone number and email provided above, including my wireless number, if applicable. I understand that I have the option to opt-out at any time.

Parent, Legal Guardian, or Authorized Signature:_____12/02/16