



Chesterfield Pediatrics Patient Information and Release (Please Print and Fill in All the Blanks)

Today's Date: _____
Child's Name: _____
Circle One: Male Female
Date of Birth: _____
Address: _____
City/State/Zip: _____

Hospital Born: _____
Sibling(s) Name and Date of Birth: _____

****Preferred Contact Number**** _____
Mother's Name or Guardian: _____ Date of Birth: _____ SSN: _____
Address (if different from child): _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Mother's Employer: _____ Employer's Address: _____

Father's Name or Guardian: _____ Date of Birth: _____ SSN: _____
Address (if different from child): _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Father's Employer: _____ Employer's Address: _____
Mother's and/or Father's E-mail Address: _____
How Were You Referred to Chesterfield Pediatrics, P.C.? _____

Insurance Company: _____
Policy/Group ID: _____
Insured's Name: _____ Date of Birth: _____
Secondary Insurance: _____ Policy/Group ID: _____
Insured's Name: _____ Date of Birth: _____

Do we have your child's Medical Records? _____ If not, please request them to be sent to us immediately.
Preferred Pharmacy Address and Phone Number _____
*In Case of Emergency Contact: _____ Relationship: _____ Phone # _____
*Name of Closest Relative Not Living With You: _____ Phone #: _____

I hereby authorize the release of medical information to any of my health care providers or insurance companies that may be pertinent to my case. I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of my medical records to third-party insurers or other persons to whom disclosure is necessary to establish or collect a fee for services provided. I understand that I am financially responsible for all charges arising from the treatment of myself (or the above named patient, if applicable). I understand that payment in full is due at the time services are rendered; however, I agree to pay a FINANCE CHARGE of 1.5% per month on balances over thirty (30) days past due, which is an ANNUAL PERCENTAGE RATE of 18%. If my account is referred to an attorney for collection, upon said referral I agree to pay attorney's fees in the amount of thirty -three and one-third percent (33-1/3%) of the total outstanding indebtedness (which includes, but is not limited to, principal, accrued interest and late charges) then due, and all costs of collection. I agree to pay the aforesaid attorney's fees and costs of collection whether or not the attorney files suit. A photocopy of the contract shall be considered as valid as the original.

I also authorize the treatment of my child by Chesterfield Pediatrics P.C., if I am not accompanying him/her to the appointment.

Print Name of Parent/Guardian

Signature of Parent/Guardian

Date: _____