THE MARYLAND PEDIATRIC GROUP, L.L.C.
PEDIATRIC CONSULTANTS, P.A.

☐ New Patient
☐ Insurance Change
☐ Address/Phone Update

Primary Physician in this Office: _____
Specialist ☐ Kenneth C. Schuberth, M.D.
☐ Other:_____

Today's Date_____/_____/_____
Referring Physician: _____
Referring Phy. Phone:_____

Patient Name_____ ☐ M ☐ F DOB_____/_____/_____
(Last) (First) (Middle)
Address_____ City _____State_____ Zip _____

Telephone (H)_____(C)_____ E-Mail _____

Siblings seen at this office (*list all)* **Children live with:** ☐ **Parents** ☐ **Mother** ☐**Father** ☐**Other**

Name_____DOB_____☐ M ☐ F Same Insurance Below ☐Y ☐N

Name_____DOB_____☐ M ☐ F Same Insurance Below ☐Y ☐N

Name_____DOB_____☐ M ☐ F Same Insurance Below ☐Y ☐N

Name_____DOB_____☐ M ☐ F Same Insurance Below ☐Y ☐N

Parent's Name_____☐ M ☐ F
Address_____Date of Birth: _____
City_____State_____Zip_____
Telephone (H)_____(C)_____
Employer/ Occupation_____ Phone (w) _____

Parent's Name_____☐ M ☐ F
Address_____Date of Birth: _____
City_____State_____Zip_____
Telephone (H)_____(C)_____
Employer/ Occupation_____ Phone (w) _____

INSURANCE INFORMATION

Primary Policy Holder_____
Insurance Co._____
Policy# _____
Group #_____Effective Date _____
Relationship To patient_____ DOB_____

Secondary Policy Holder_____
Insurance Co._____
Policy # _____
Group #_____Effective Date _____
Relationship To patient_____ DOB_____

Assignment of Benefits: I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company (s), I will be held directly responsible for all fees incurred with The Maryland Pediatric Group L.L.C./Pediatric Consultants.

I understand that I am responsible for copayments, coinsurance, deductibles or services not covered by my insurance. I acknowledge that I am responsible for payment in full in the event the provider of services does not participate with my insurance plan. I also understand that I am responsible for providing a referral form at the time of service (before services are rendered) if required by my insurance plan. If I elect to see the provider of services without the necessary referral form, I understand that I am responsible for payment in full at the time of service and that my insurance may deny my claim. I authorize payment of medical benefits to the physician or provider for all services rendered. I also authorize the release of any medical information requested for the processing of the claims for myself (or my minor child).

I have received information regarding the privacy practices of The Maryland Pediatric Group L.L.C./Pediatric Consultants as it relates to me or my child(ren) as defined by state and federal regulations.

Parent/Guarantor/LegalGuardian_____Date_____

☐ I am 18 years of age or over and give my parents permission to discuss my medical history with my physician.

Patient Signature_____ Print Name_____