Porter Pediatrics
754 Tremont Street, Boston, MA

Patient information:

Last Name:	**First Name:**	**Middle Initial:**	
Date of Birth:	**Sex:**	**Social Security #:**	
Home Street Address:	**City:**	**State:**	**Zip Code:**

Parent/Guardian Information:

Parent/Guardian living with Child:

Last Name:	**First Name:**	**Middle Initial:**	
Date of Birth:	**Social Security #:**	**e-mail address:**	
Home Street Address:	**City:**	**State:**	**Zip Code:**
Employer:	**Home Phone**	**Work Phone**	**Cell Phone**

Other Parent/Guardian

Last Name:	**First Name:**	**Middle Initial:**	
Date of Birth:	**Social Security #:**	**e-mail address:**	
Home Street Address:	**City:**	**State:**	**Zip Code:**
Employer:	**Home Phone**	**Work Phone**	**Cell Phone**

Insurance Information:

Primary Insurance

Company Name:	**Policy ID #:**	**Group #:**	
Address:	**City:**	**State:**	**Zip Code:**
Last Name:	**First Name:**	**Middle Initial:**	

Secondary Insurance:

Company Name:	**Policy ID #:**	**Group #:**	
Address:	**City:**	**State:**	**Zip Code:**
Last Name:	**First Name:**	**Middle Initial:**	

I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to Porter Pediatrics for services rendered. In the event that my medical insurance does not pay for the services rendered, I agree to pay Porter Pediatrics the usual and customary fees for these services.

Please make sure the front office has a copy of your insurance card.

Signed: _____ Date: _____