THE CARITHERS PEDIATRIC GROUP

PEDIATRICS AND ADOLESCENT MEDICINE

2121 PARK STREET
JACKSONVILLE, FL 32204

10475 CENTURION PARKWAY N., SUITE 301
JACKSONVILLE, FL 32256

Patient's Name _____
Last First MI

Address _____ City: _____ State: _____ Zip _____

DOB: _____ Gender _____ Home Phone: _____

Email Address: _____

Caregiver 1 Name _____ Relationship _____

DOB _____ Age _____ SS# _____

Employer _____ Cell Phone _____

Work Phone _____

Caregiver 2 Name _____ Relationship _____

DOB _____ Age _____ SS# _____

Employer _____ Cell Phone _____

Work Phone _____

Caregiver 1 Insurance Company _____ Group # _____ Policy# _____

Issue Date _____ Expiration Date _____ Phone# _____

Address where claims should be submitted _____

Caregiver 2 Insurance Company _____ Group # _____ Policy# _____

Issue Date _____ Expiration Date _____ Phone# _____

Address where claims should be submitted _____

Who other than parents is allowed to bring your child to the doctor (please note the relationship to child)

Name _____ Relationship _____ DL# _____

Name _____ Relationship _____ DL# _____

Name _____ Relationship _____ DL# _____

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.
A copy of this signature is as valid as the original.

Signature and Date _____ Signature and Date _____

Please send a copy of immunizations with this form