Gabriel Pediatrics, PC

Patient Name_____Date of Birth_____

Primary Insurance Information

Primary Insurance Carrier Name	Primary Insurance Carrier Address and Phone
Policy Holder's Name (Responsible Party)	Employer/Group Name
Policy I.D. #	Group Number
Primary Care Physician chosen (if applicable)	

Please note: We do not accept Secondary insurance, we will gladly provide you with a receipt to submit to your insurance.

I, the undersigned certify that I (or my dependent) have insurance coverage with the above and assign directly to Gabriel Pediatrics, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Gabriel Pediatrics, PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship to Patient Date