EAST MILTON PEDIATRIC ASSOC., INC.
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Elizabeth E. Bodner, M.D.
Anthony F. Bonacci, M.D.
Kathleen M. Fitzgerald, M.D.

Betsy A. Sisson, M.D.
Mary Ellen Timmins, M.D.

Last name of child _____ First _____
Address _____ City/State/Zip _____
DOB _____
Hospital Name _____ Home Phone (___) _____
Mothers Name _____ DOB _____
Mothers Occupation _____ Mothers Cell (___) _____
Mothers Work (___) _____
Fathers Name _____ DOB _____
Fathers Occupation _____ Fathers Cell (___) _____
Fathers Work (___) _____
Name and Phone Number of Grandparents or Friend: _____

Name of Insurance Plan _____
First and Last Name of Subscriber _____
Group Number _____
Employer Name _____
Telephone (___) _____
Relation to Subscriber _____

MEDICAL INFORMATION AND PAYMENT AUTHORIZATION

I request that payment of authorized medical benefits be made on my behalf to Kathleen Fitzgerald M.D. for services rendered. I authorize any holder of medical information about me to release it to the healthcare financing administration or any other insurer, any information needed to determine these benefits payable to related services.

Signature: _____ Date: _____

PLEASE PAY YOUR COPAY AT THE TIME OF THE VISIT- THANK YOU

Please add child to insurance plan. They will not automatically do it without a call from the subscriber. Thank you.