# Pediatric Feeding Institute
## South Florida

### Insurance Verification

Please enter the information requested below. All fields must be filled out.

**Parent Information**

Your name: ______________________________________________________

Your email: ______________________________________________________

Your phone: _____________________________________________________

Your address: ____________________________________________________

____________________________________________________

### Child Information

Child's Name: ___________________________________________________

Date of Birth: _______________________________

Child's Diagnosis and Feeding Difficulties: _____________________________________________

___________________________________________________________________________

___________________________________________________________________________

Pediatrician's Name: _____________________________________________

### Insurance Information

Primary Insured's Name: _________________________________________

Insurance Company: ____________________________________________

Insurance ID Number: _____________________ Insurance Group Number:________________

Phone: _____________________________________