Acct #: _____

FAMILY INFORMATION

(PLEASE COMPLETE BOTH SIDES)

Date: _____

PATIENT(s) NAME **SEX** **DATE OF BIRTH** **SOCIAL SECURITY #**

_____

_____

_____

_____

_____

Home Address _____ **Phone # ( )**_____

City _____ **State** _____ **Zip** _____

E-mail address: _____

Primary Care Provider (Physician/Nurse Practitioner) _____

Circle One: Mother / Father / Guardian

Name_____ **Date of Birth** _____ **Social Security #**_____

Address _____ **Phone # ( )**_____

Employer _____ **Phone # ( )**_____

Employer's Address _____

Circle One: Mother / Father / Guardian

Name_____ **Date of Birth** _____ **Social Security #**_____

Address _____ **Phone # ( )**_____

Employer _____ **Phone # ( )**_____

Employer's Address _____

Primary Health Insurance Co. _____ **Phone # ( )** _____

Policy ID # _____ **Group #** _____

Policy Holder_____ **Relationship to Patient** _____

Secondary Health Insurance Co. _____ **Phone # ( )** _____

Policy ID # _____ **Group #** _____

Policy Holder_____ **Relationship to Patient** _____

PLEASE TURN OVER ☞

In Case of Emergency Contact (other than parent) _____

Relationship to Patient_____ Phone # ( ) _____

Patient Referred By _____

AUTHORIZATION TO SEEK MEDICAL TREATMENT

The following individuals are hereby authorized to seek medical treatment for my child(ren) in my absence:

Name: _____ Relationship to Patient _____

Name: _____ Relationship to Patient _____

Signature of Parent/Guardian _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGN BENEFITS

I hereby authorize the release of any medical information necessary to process an insurance claim and in the case of assigned benefits, do hereby authorize payment to be sent directly to the physician.

Signature of Parent/Guardian _____ Date _____

ASSUMPTION OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible to the doctor for all charges incurred on my account whether covered by my insurance company or not. These charges are to be paid at the time services are rendered unless submitted to an insurance company with whom the Pediatric Group has a participating contract. I also understand that non-covered services under my insurance policy and outstanding balances become my full responsibility. In the event collections proceedings are instituted to enforce payment of fees due to the Pediatric Group I/we, the undersigned agree to pay the additional sum of twenty-five percent (25%) of the principal due as attorney fees, plus all associated court fees.

Signature of Parent/Guardian _____ Date _____

FAMILY NEEDS FOR AUXILIARY AIDS or SERVICES ❑ Yes ❑ No

Type of aid requested: ❑ vision ❑ hearing ❑ language: primary language_____

Name(s) of individual(s) needing aid:_____

Preferred method of communication in office:_____

Preferred method of communication outside office (name any authorized individuals):_____

The practice will provide requested communication aids to patients without charge as reasonably available and appropriate.

IT IS YOUR RESPONSIBILITY TO NOTIFY THIS OFFICE IMMEDIATELY OF ANY CHANGES TO THE ABOVE INFORMATION. I HAVE REVIEWED THE 2011 INFORMATION. MY FAMILY'S PERSONAL AND INSURANCE INFORMATION HAS NOT CHANGED

Name _____ Date_____ Relationship to Patient: _____