

Patient Information

Patient's Name: _____ Date of Birth : _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____

Cell number: _____

Work number: _____

Pediatrician: _____ Phone#: _____

Pediatrician's address: _____

Family Information

Please circle:

Mother/Father/Guardian: Full Name: _____

Mother/Father/Guardian: Full Name: _____

Check here if Self Pay _____ **Insurance Information**

Primary

Insurance: _____ Identification # : _____

Group#: _____ Co-pay Amount: (Specialist) _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

SS#: _____ Insured's Employer: _____

City, State, & Zip (on back of card) _____

Secondary (If any)

Insurance: _____ Identification #: _____

Group: _____ Co-Pay Amount: _____

Insured: _____ Insureds Date of Birth: _____

SS #: _____ Insureds Employer: _____

Telephone #: _____ Employer's Address: _____

City, State, & Zip: _____

Authorization and Release

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, and /or other health practitioners. I authorize and request my insurance company to pay directly to the doctor's insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

X _____

Signature of Patient or Guardian if Minor

Date

*** Please sign second page for your rights to privacy.**