

PATIENT INFORMATION FORM

HOME ADDRESS: _____

HOME PHONE: _____

CITY / STATE / ZIP: _____

MOTHER OR GUARDIAN: SS #: _____

MOTHER EMPLOYER: _____

MOTHER'S WORK PHONE: _____

MOTHER'S CELL PHONE: _____

MOTHER'S DOB: _____

FATHER OR GUARDIAN: SS #: _____

FATHER EMPLOYER: _____

FATHER'S WORK PHONE: _____

FATHER'S CELL PHONE: _____

FATHER'S DOB: _____

REFERRED BY: _____

NAME OF FRIEND/RELATIVE NOT LIVING WITH YOU: PHONE:

PRIMARY INSURANCE CO: _____

PRIMARY INSURED'S NAME: _____

INSURANCE ADDRESS: _____

CITY / STATE / ZIP: _____

GROUP#: _____

INSURANCE ID #: _____

INSURED'S NAME: _____

OTHER INSURANCE INFO AND ID #: _____

DO WE HAVE PERMISSION TO ADD YOUR EMAIL ADDRESS TO OUR PEDIATRICS IN PARADISE NEWSLETTER DATABASE SO THAT YOU MAY RECEIVE OUR MONTHLY NEWSLETTERS? (WE WILL NOT SHARE YOUR EMAIL FOR ANY OTHER PURPOSE).

NO / YES AND THEN ENTER EMAIL ADDRESS BELOW:

EMAIL: _____

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THE UNDERSIGNED AGREES THAT ALL SERVICES ARE RENDERED ON A PAID BASIS ONLY. OUR POLICY IS TO COLLECT FOR SERVICES AT THE TIME THEY ARE RENDERED. IF COLLECTION BECOMES NECESSARY, THE UNDERSIGNED SHALL PAY ALL REASONABLE COSTS.

WE WILL BILL INSURANCE FOR THOSE COMPANIES THAT WE HAVE A CONTRACTUAL OBLIGATION TO DO SO. THE UNDERSIGNED AGREES TO AUTHORIZE INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. THE UNDERSIGNED IS RESPONSIBLE FOR ALL NON-COVERED SERVICES. THE UNDERSIGNED AUTHORIZES THE PHYSICIAN TO PROVIDE ANY INFORMATION REQUIRED TO PROCESS CLAIMS FOR BENEFITS.

PARENTS AGREE TO HAVE CHART NOTES COPIED AND FORWARDED WHEN REQUESTED BY SPECIALIST OR SCHOOL.

MOTHER OR GUARDIAN SIGNATURE DATE

MOTHER OR GUARDIAN (PRINT NAME)

FATHER OR GUARDIAN SIGNATURE DATE

FATHER OR GUARDIAN (PRINT NAME)