Patient Information

Last Name ______ First ______ Middle ______ Date of Birth ______ Male / Female

Address ______ Apt. # ______ City ______ State ______ Zip ______

Home Phone (____) ______ Referred By: ______

Other Children Information

Last Name ______ First ______ Middle ______ Date of Birth ______ Male / Female

Last Name ______ First ______ Middle ______ Date of Birth ______ Male / Female

Last Name ______ First ______ Middle ______ Date of Birth ______ Male / Female

Last Name ______ First ______ Middle ______ Date of Birth ______ Male / Female

Parent Information

Parent or Guardian's Name ______ Work Phone (____) ______ Cell Phone (____) ______

Occupation ______ Date of Birth ______

Email Address ______ Employer's Phone (____) ______

Parent's Social Security # ______ Parent's Driver's License # ______

Parent or Guardian's Name ______ Work Phone (____) ______ Cell Phone (____) ______

Occupation ______ Date of Birth ______

Email Address ______ Employer's Phone (____) ______

Parent's Social Security # ______ Parent's Driver's License # ______

Billing Address, if different ______

Insurance Information

Please present your insurance card and driver's license to the receptionist so that a copy may be made. **Also, please be familiar with your insurance coverage. Some plans will not cover a well-visit if your child is sick, some require a second co-pay or will apply a portion toward your deductible. When we verify your insurance coverage your plan will not give us that information.**

Signed ______ Date ______

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to the attending physician. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by the said insurance. I hereby authorize said assigned to release all information that may be necessary to secure payment.

I understand that I am financially responsible for all charges whether or not paid by said insurance.

A fee of $25.00 will be assessed for no show appointments without 24 hours notice given.

Signed ______ Date ______

POS Reorder # 0813034