Patient Information

Last Name ____ First ___________________________________ Middle ____________________

Date of Birth _________/_________/______________ Male / Female Referred By: ____

Address ____ Apt # _________ City __________________ State ______ Zip _____________

Other Children Information

Last Name _____________________________ First ___________________________ Middle _____________ Date of Birth ____/____/_______

Last Name _____________________________ First ___________________________ Middle _____________ Date of Birth ____/____/_______

Last Name _____________________________ First ___________________________ Middle _____________ Date of Birth ____/____/_______

Last Name _____________________________ First ___________________________ Middle _____________ Date of Birth ____/____/_______

Parent/Legal Guardian Information

The Primary Contact information below must be whoever is accepting Financial Responsibility by signing at the bottom of this form.

Primary Contact: Last Name ________________________________ First ______________________________ Date of Birth ____/____/_______

Cell Phone: _____-_____-_________ Work Phone: _____-_____-_________ Email Address: ____

Relationship to Patient: ____ Occupation: ____

Social Security #: _________-__________-______________ Driver's License #: ____

Secondary Contact: Last Name _______________________________ First _____________________________ Date of Birth ____/____/_______

Cell Phone: _____-_____-_________ Work Phone: _____-_____-_________ Email Address: ____

Relationship to Patient: ____ Occupation: ____

Social Security #: _________-__________-______________ 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 may have a deductible, will not cover a well-visit if your child is sick, or may require a minimum of 12 months between well-visits for children over the age of two. When we verify your insurance coverage, your plan will not provide our office with this information.**

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 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.

I understand that a fee of up to $50.00 will be assessed for no-show appointments, or appointments not cancelled within 24 hours.

Signature: ____ Date: ______/______/_________

Revised 12/2024