PATIENT INFORMATION

ALLERGIES TO MEDICATIONS:

PLEASE PRINT ☐ FEMALE ☐ MALE

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ HOME PHONE: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

PARENT/GUARDIAN INFORMATION

☐ CHECK IF GUARANTOR (person responsible for charges not covered by insurance)

MOTHER'S NAME: _____ BIRTHDATE: _____

ADDRESS: _____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ HOME PHONE: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE NUMBER: _____ MAY WE CALL YOU AT WORK? ☐ YES ☐ NO

☐ CHECK IF GUARANTOR (person responsible for charges not covered by insurance)

FATHER'S NAME: _____ BIRTHDATE: _____

ADDRESS: _____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ HOME PHONE: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE NUMBER: _____ MAY WE CALL YOU AT WORK? ☐ YES ☐ NO

PEDIATRICIAN INFORMATION

PEDIATRICIAN NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

REASON FOR TODAY'S VISIT: _____

**** PLEASE COMPLETE AND SIGN REVERSE SIDE ****

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

POLICYHOLDER NAME: _____ POLICYHOLDER BIRTHDATE: _____

POLICYHOLDER SS#: _____ RELATIONSHIP TO PATIENT: _____

CO-PAY: _____

SECONDARY INSURANCE

INSURANCE COMPANY NAME: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

POLICYHOLDER NAME: _____ POLICYHOLDER BIRTHDATE: _____

POLICYHOLDER SS#: _____ RELATIONSHIP TO PATIENT: _____

CO-PAY: _____

AUTHORIZATION and RELEASE OF INFORMATION

I am giving USA permission to ask for third party payor/Medicare payments for my child's medical care. I understand that third party payor/Medicare needs information about my child and his/her medical condition to make a decision about these payments. I give permission for that information to go to third party payor/Medicare and the companies that handle third party payor/Medicare payment requests. I understand that the Health Care financing Administration (HCFA) is the government Medicare agency. I request that payment of authorized third party payor/Medicare benefit be made either to me or on my child's behalf for any services furnished my child by USA, including physician services. I authorize any holder of medical or other information about my child to release to the HCFA and its agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature Date

TO BE UPDATED EVERY SIX MONTHS:

I have reviewed information on this sheet and it is accurate.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date