UPDATED PATIENT INFORMATION

CHILD'S NAME:____ **SEX:** ☐Male
Last First Middle ☐Female

DATE OF BIRTH: ____________________________

HOME ADDRESS ____

CITY____STATE___________ZIP CODE________________

EMAIL ADDRESS:_________________________________

HOME PHONE #(_______)________________________ May we leave messages at this number?___________

MOTHER'S CELL PH #(_____)_____________________ FATHER'S CELL PH#(_____)______________________
May we leave a detailed message at this number?_______ May we leave a detailed message at this number?____

MOTHER'S NAME______________________________Birthdate ___________ SS#_______-_______-______
EMPLOYER ____PHONE #(______)________________
FATHER'S NAME_______________________________Birthdate_____________SS#_______-_______-______
EMPLOYER____PHONE #(______)_______________

DO YOU HAVE MEDICAL INSURANCE? ☐YES ☐NO IF YES, PLEASE PROVIDE COPIES OF ALL CARDS
NAME OF PRIMARY INSURER____
Subscriber Name/DOB____
NAME OF SECONDARY INSURER____
Subscriber Name/DOB____
Please note - we do not accept Kaiser Permanente

****PLEASE PRESENT CARDS AT TIME OF SERVICE****

How did you hear about our office?____
____

THANK YOU FOR CHOOSING US AS YOUR CHILD'S HEALTH CARE PROVIDER. WE ARE COMMITED TO YOUR CHILD'S HEALTH. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS NECESSARY TO MAINTAIN THE HIGH QUALITY MEDICAL CARE WE ARE COMMITTED TO. TO FACILITATE CLAIM APPROVAL, ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM AT THE FIRST VISIT IN OUR OFFICE OR WHENEVER THIS INFORMATION CHANGES. **FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER. ALL CO-PAYS AND DEDUCTIBLES ARE DUE PRIOR TO LEAVING THE OFFICE.** IF THE INSURANCE COMPANY IN WHICH WE ARE A PROVIDER FAILS TO PAY YOUR ACCOUNT IN FULL WITHIN 60 DAYS, THE BALANCE IS YOUR RESPONSIBILITY. SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS MATTER, PLEASE ASK ANY OF THE OFFICE STAFF. THE ADULT ACCOMPANYING MINOR PATIENTS OR PARENT(S)/GUARDIAN(S) OF THE MINOR ARE RESPONSIBLE FOR FULL PAYMENT.

I HAVE READ THE ABOVE INFORMATION AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED PHYSICIANS. I HEREBY AUTHORIZE MY CONSENT FOR TREATMENT FOR THE ABOVE NAMED CHILD. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS.

SIGNED____ TODAY'S DATE__________________________