# Children's Physicians

## PATIENT INFORMATION SHEET

Primary Language Spoken: ____________________________

**PLEASE FILL OUT COMPLETELY:** Today's Date ____________________________

Name of Child ___________________________________ Sex______________ Birthdate ________________

CHILD'S SS# ________________________________ ALLERGIES ____________________________

HOME PHONE__________________ CELL PHONE (MOM)_____________(DAD)_______________

E-Mail Address ______________________________________________________________

Home Address ___________________________ City __________________ State _____ Zip ___________

Mailing Address ______________________________________________________________

Father's Name ______________________________________ (Step or Biological) Birthdate _____________

SS# _____________________________________ Drivers License # ____________________________

Work Name _________________________________ Work Phone # ____________________________

Work Address ______________________________________________________________

Mother's Name _____________________________________ (Step or Biological) Birthdate _____________

SS# _____________________________________ Drivers License # ____________________________

Work Name _________________________________ Work Phone # ____________________________

Work Address ______________________________________________________________

Name of Person Child Lives With _____________________________________________

Relationship of Biological Parents to each other: MARRIED---DIVORCED---SINGLE---WIDOWED

WHO IS RESPONSIBLE FOR PAYMENT? Name: ________________________________________

Which Parent is Policyholder _______________________________________________

Insurance Company Name _________________________________________________

Insurance Company Address _______________________________________________

Policy # ____________________________________ Group#/Plan Name# __________________________

Other Children That Come To This Office (DOB & SS#) ___________________________________

Name/Address of Nearest Relative Not In Same House ___________________________________

### *ASSIGNMENT AND RELEASE*

I hereby authorize payment directly to Children's Physicians, all insurance benefits otherwise payable to me for services rendered. I authorize Children's Physicians to release any information required to secure payment of benefits from my insurance. I authorize the use of this signature on all insurance submissions, and to download any available medication history.

Signature of Responsible Party ___________________________________ Date ____________________

Print Name ________________________________________________

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## ASSIGNMENT OF BENEFITS

On behalf of this child, I authorize the release of any payment and medical information necessary to process this claim and related claims. I request payment of benefits to Children's Physicians, who accepts assignment of benefits.

## CONSENT FOR TREATMENT

On behalf of this child, I voluntarily consent to the rendering of medical care by Children's Physicians. I understand that the child is under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s).

## STATEMENT OF FINANCIAL LIABILITY

I guarantee payment of any and all bills rendered for said child which are not covered or allowable by insurance. This office will file the bill with my insurance company, providing I supply the proper insurance information to this office.

I understand if I have an unpaid balance to Children's Physicians and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Children's Physicians or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Children's Physicians and the designated external collection agency are authorized to (1) contact me by telephone at the telephone number(s) I am providing, including wireless telephone

## AUTHORIZATION TO RELEASE INFORMATION

I authorize Children's Physicians to release any and all information required in the course of the examination and/or treatment for the purpose of insurance, auto or school accident, and/or Medicaid benefit payments.

## NON COVERED SERVICES

I acknowledge that procedures and services not covered by my insurance company will be my responsibility and payment will be submitted immediately.

**Who referred you to the practice?** ______________________________

Authorized Person's Signature: ______________________________

Date: ____________________