

PATIENT INFORMATION SHEET

THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVICE YOU PROPERLY WE WILL NEED THE FOLLOWING INFORMATION. PLEASE PRINT. ALL INFORMATION WILL BE KEPT CONFIDENTIAL

FAMILY LAST NAME _____
MOTHERS NAME _____ **FATHERS NAME** _____

CHILDRENS NAME _____ **DATE OF BIRTH** _____ **SEX** _____

ADDRESS _____ **CITY** _____ **ST** _____ **ZIP CODE** _____
HOME PHONE NUMBER _____ **CELL PHONE NUMBER** _____

RESPONSIBLE PARTY
PERSON RESPONSIBLE FOR ACCOUNT _____
RELATIONSHIP TO PATIENT _____ **SOC SEC #** _____
ADDRESS _____ **HOME PHONE** _____
EMPLOYER _____ **WORK PHONE** _____

INSURANCE INFORMATION
NAME OF INSURED _____ **RELATIONSHIP TO PATIENT** _____
BIRTHDATE _____ **SOCIAL SECURITY #** _____
NAME OF EMPLOYER _____ **WORK PHONE** _____
ADDRESS OF EMPLOYER _____ **CITY** _____ **ST** _____ **ZIP** _____
NAME OF INSURANCE CARRIER _____
INS CO ADDRESS _____ **CITY** _____ **ST** _____ **ZIP** _____
INSURANCE ID# _____ **GROUP #** _____ **COPAY** _____

WHO REFERRED YOU TO OUR PRACTICE? _____

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY CHILD'S HEALTHCARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

X _____
NAME OF PARENT/GUARDIAN _____ **DATE** _____