PATIENT INFORMATION PROFILE

Date _____ Date of Birth _____

Patient's Primary Physician At This Office _____

Patient's Name _____ Age _____ Sex _____
First Middle Last

Cell # _____

Address _____ Home # _____
Street Address Apt. No.

_____
City County State Zip

Father's Name _____ DOB: _____ SS# _____

Address _____

Employed By _____ Business # _____

Mother's Name _____ DOB: _____ SS# _____

Address _____

Employed By _____ Business # _____

Emergency Contact (not living with you) _____
First Middle Last

Address _____
Street City State Zip

Home Phone # _____ Business # _____

Parent who is financially responsible for child's account balance _____

Do you have insurance? ☐ Yes ☐ No *If yes, please provide us with a copy of your card.*

Do you have medicaid? ☐ Yes ☐ No *If yes, please provide us with a copy of your child's card.*

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION - I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT - I understand that I am financially responsible for all charges for service rendered to my child/children, including the balance remaining after payment of possible insurance benefits.

_____ _____

Signature *Date*