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 State Zip

Father's Name_____ SS# _____

Address_____

Employed By_____ Business #_____

Mother's Name_____ SS#_____

Address_____

Employed By_____ Business #_____

Next of Kin (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.

_____

Signautre *Date*