PATIENT INFORMATION

PLEASE PRINT CLEARLY TODAY'S DATE ______________________

Child's Name: ____
(Last) (First) (Middle)

Date of Birth: ______________________ Age: ______________ Sex: ________________

Address: ______________________________________ Home Phone: (_______) ______________
(Area Code)

______________________________________ Child's SS#: ______________________
(City) (State) (Zip)

Primary/Ref. Doctor: ____
(Last) (First)

Primary/Ref. Clinic: ______________________________Clinic Phone: (_______) ______________
(Area Code)

Address: ____

Primary Pharmacy ______________ Address ______________________ Phone ________________

Has this **child** been seen by our Dr.'s before? ____________ If yes, Where? ______________________

Reason for Today's Visit? ____

Whom may we thank for referring you? ____

PARENT / GUARDIAN INFORMATION

Mother/Guardian Name: ____
(Last) (First) (Middle)

D.O.B. ______________ Social Security No.: ______________________ Marital Status: **M S W D SEP**

Employer: ______________________ Business Ph: (_____) ______________ Cell Ph: (_____) ______________
(Area Code) (Area Code)

Home Address (if different from child):____

Father/Guardian Name: ____
(Last) (First) (Middle)

D.O.B. ______________ Social Security No.: ______________________ Marital Status: **M S W D SEP**

Employer: ______________________ Business Ph: (_____) ______________ Cell Ph: (_____) ______________
(Area Code) (Area Code)

Home Address (if different from child): ____

PATIENT INSURANCE / MEDICAL ASSISTANCE INFORMATION

Insurance Company: ____

Insurance Co. Address: ____

____
(City) (State) (Zip)

Name of Policy Holder: ______________________________ Effective Date: ______________________

INSURANCE GROUP NUMBER: ______________________ Insurance I.D. Number: ______________________

Medical Assistance I.D. Number: ______________________ County: ______________ State: __________

OTHER INSURANCE:

Insurance Company: ____

Insurance Co. Address: ____

____
(City) (State) (Zip)

Name of Policy Holder: ______________________________ Effective Date: ______________________

Insurance Group Number: ______________________ Insurance I.D. Number: ______________________

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, INCLUDING MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO: PEDIATRIC SURGICAL ASSOCIATES, LTD.
THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO PURSUE COLLECTIONS FROM THIRD PARTY PAYORS IN MY NAME AND TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNED: ____ DATE: ______________________

Relationship to Patient: ______________________ E-mail: ______________________