

If other Parent or Guardian has no legal right to the child's information, you must provide written documentation from the Courts stating such facts, otherwise we will furnish the records to the other Parent or Guardian upon request.

Primary Insurance

() Family Policy () Individual () Other

Effective Date: _____

Insured Party: _____

Relationship to Patient: _____

Insured Phone: _____

Insured ID: _____

Insurance Company: _____

Group#: _____ Co Pay _____

Secondary Insurance

() Family Policy () Individual () Other

Effective Date: _____

Insured Party: _____

Relationship to Patient: _____

Insured Phone: _____

Insured ID: _____

Insurance Company: _____

Group#: _____ Co Pay _____

Emergency Contact

Name: _____

Relationship: _____

Address: _____

Phone # _____

Additional Information:

Pharmacy Name and #: _____

Email Address: _____

We will automatically file your insurance claim if we have a copy of your insurance card and if the Assignment of Benefits is signed below. This information must be updated annually and when your insurance changes. You are responsible for what insurance does not pay within 30 days of the insurance receipt. Any cost incurred with the collection of your account is your responsibility. If you have any questions concerning your account or the filing of your insurance, please contact the bookkeeping office Monday- Thursday 8:30 am to 4:00 pm @ 452-6707.

Release of Information and Assignment Benefit

I hereby authorize release of any medical information necessary to process my insurance claim.

X _____

I hereby authorize payment directly to Drs. Roth, Lehocky, Katz, Belza, Abrams, Newstadt, and Johnson.

X _____

PATIENT PROFILE

Chart # _____

Date: _____

Child(ren) Information

<u>Name</u>	<u>DOB</u>	<u>Sex</u>	<u>Name</u>	<u>DOB</u>	<u>Sex</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Parent or Guardian Information

Mother: _____

Father: _____

Address: _____

Address: _____

Phone: _____ () Home () Work () Cell

Phone: _____ () Home () Work () Cell

Phone: _____ () Home () Work () Cell

Phone: _____ () Home () Work () Cell

Phone: _____ () Home () Work () Cell

Phone: _____ () Home () Work () Cell

Employer: _____

Employer: _____

Occupation: _____

Occupation: _____

Address: _____

Address: _____

Mothers DOB: _____ SSN: _____

Fathers DOB: _____ SSN: _____

() Married () Single () Divorced

() Married () Single () Divorced

() Custodial Parent () Guardianship () Joint Custody

() Custodial Parent () Guardianship () Joint Custody

Other Parent or Guardian

Name: _____

Employer: _____

Address: _____

Address: _____

Phone: _____ () Home () Work () Cell

Date of Birth: _____

Phone: _____ () Home () Work () Cell

Is other Parent or Guardian permitted by law to have access to the child's medical records? Yes or No.

Phone: _____ () Home () Work () Cell

PLEASE SEE BACK FOR ADDITIONAL INFORMATION

