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AND ASSOCIATES



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Date: ___/___/___

Patients Name: _____ Date of Birth ___/___/___ Age: ___
(Please put middle initial)

Sex: M / F SSN: _____ - _____ - _____ Home Phone: () _____ - _____

Cell Phone: _____ Baby's Birth Weight _____ #of Weeks _____

Street Address: _____ City: _____ State: _____ Zip: _____

Referred By: (How did you hear about us?) _____ Email: _____

Father's Name: _____ Date of Birth: ___/___/___ SSN: _____ - _____ - _____

Employer Name: _____ Work Phone: () _____ - _____ Ext: _____

City: _____ State: _____ Zip: _____

Home Phone() _____ - _____ Cell Phone () _____ - _____

Mother's Name: _____ Date of Birth: ___/___/___ SSN: _____ - _____ - _____

Home Phone: _____ - _____ Cell: _____ - _____

Responsible Party/Insured: _____ Phone: () _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Name: _____ Insurance Company Phone: () _____ - _____

Insurance Policy Number: _____ Group Number: _____

Relationship to Patient: Parent Self Other: _____

Is your Child allergic to any Medications (Y / N)? ___ Is your child allergic to any foods, tapes, dye, or other (Y / N)? ___ If yes, Please describe the type of allergic reaction: _____

In case of emergency Contact (different from Parent): _____ Phone:() _____ - _____

Signature on File

I authorize the use of this form, and information on all my insurance submissions, I authorize release of information to my insurance company(ies), I authorize payment directly to my doctor, I understand I am responsible for my bill, I permit a copy of this authorization to be used in place of the original, I authorize my doctor to act as my agent in helping me to obtain payment from my insurance company(ies), I understand I am responsible for payment in full if my insurance does not cover services. I understand that co-pay and deductible are my financial responsibility.