Brian Despinasse II, M.D.
AND ASSOCIATES

FERTILE CRESCENT®
PEDIATRICS

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Patients Name:____________________________ Date of Birth_____/____/_____Age:_____

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

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:________

Employer Address: ______________________ City:_______________ State:______ Zip:_______

Home Phone( )_______-________ Cell Phone ( ) ________- ____________

Responsible Party/Insured: _______________________ Phone: ( ) ________- _________

Mailing Address: _____________________ City:_____________ State: ________ Zip:___________

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

Claims Address : __________________ City: _____________ State: _______ Zip:______________

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 pays or deductibles are required at time of services to my doctor.