All Children Pediatrics - Patient Profile

Patient Information

Name: ______________________________________

Address: ______________________________________

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City: ______________________________________

State: ______________________________________

Zip Code: ______________________________________

Phone: Home: ________________________________

Cell: ________________________________

Work: ________________________________

Patient ID#: ________ Sex: [ ] M [ ] F

Date of Birth: ____

Patient's SS# ____

Primary Physician of Choice: _________________________________

Who Referred You? ____

E-mail Address for Newsletters/updates _________________________

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Emergency Contacts

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Guarantor (Insurance Policy Holder)

Name: ______________________________________

Address: ______________________________________

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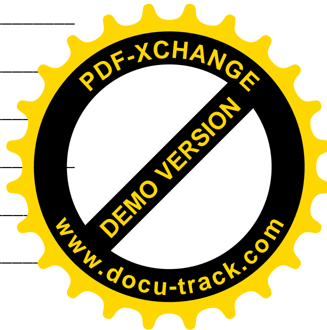
City: ______________________________________

State: ______________________________________

Zip Code: ______________________________________



Guarantor's Employment

Employer: ____________________________________

Phone: ____________________________________

Social Security# _________________________________

Date of Birth: _________________________________

Primary Insurance

[ ] Same as Guarantor [ ] Other

Insured Party: ______________________________________

Date of Birth: ______________________________________

Insured Phone: ______________________________________

Company: ______________________________________

Relationship to Patient ______________________________________

Social Security #: ______________________________________

Insured ID: ______________________________________

Policy Group: ______________________________________

Secondary Insurance

[ ] Same as Guarantor [ ] Other

Insured Party: ______________________________________

Date of Birth: ______________________________________

Insured Phone: ______________________________________

Company: ______________________________________

Relationship to Patient ______________________________________

Social Security #: ______________________________________

Insured ID: ______________________________________

Policy Group: ______________________________________

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to All Children Pediatrics all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I request and give consent to any physician to provide and perform such medical/surgical care, test, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician.

____ ___________________________________

Signature of Parent /Guardian Date