Patient Information

Patient Name: _____

Mailing Address: _____

City/State/Zip: _____ **Phone:** (___) _____

Date of Birth: _____ **Sex: Male / Female**

Social Security Number: _____

Emergency Contact

Contact Name: _____ **Home Phone:** (___) _____

Additional Phone: (____) _____ **Relationship to Patient:** _____

Responsible Party If Not Patient

Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Sex: Male / Female**

Home Phone: (___) _____ **Cell Phone:** (___) _____

Additional/Alternative Phone: (___) _____

Mailing Address: _____

City/State/Zip: _____

Employer Name: _____ **Employer Number:** (___) _____

Relationship to Patient: _____

Insurance

Insurance Name: _____ **Co-pay:** _____

Subscriber Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Home Phone:** (___) _____

Sex: Male / Female Mailing Address:
_____

City/State/Zip: _____

Employer Name: _____ Employer Number: (___)_____
_____

Relationship to Patient: _____

(Only Applicable if there is an additional insurance to the primary Insurance)

Secondary Insurance Name: _____ Co-pay:
_____

Subscriber Name: _____ Date of Birth:
_____

Social Security Number: _____ Home Phone:
(___)_____

Sex: Male / Female Mailing Address:
_____

City/State/Zip: _____ Employer Name:
_____

Employer Number: (___)_____ Relationship to Patient:
_____

Other Information/Consent

Leave Messages: Home: Yes / No Work: Yes / No

Email Address: _____

Pharmacy Name/Location: _____

Pharmacy Number: (___)_____

I hereby authorize the assignment of benefits (payments) directly to KidzLife Pediatrics for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party:

_____ Date: _____

Who can we thank for this referral: _____