Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Sex:
Race:	Ethnicity:	Language:
Child Resides With (Please list father, mother, both, or other):		
How did you hear about us?		

Responsible Party Information

Father's Last Name:	Father's First Name:				Middle Initial:
Date of Birth:	Social Security Number:				Marital Status:
Address:					
City:	State:				Zip Code:
Primary Phone Number:		Please Circle:	Home	Work	Cell
Secondary Phone Number:		Please Circle:	Home	Work	Cell
Mother's Last Name:	Mother's First Name:				Middle Initial:
Date of Birth:	Social Security Number:				Marital Status:
Address:					
City:	State:				Zip Code:
Primary Phone Number:		Please Circle:	Home	Work	Cell
Secondary Phone Number:		Please Circle:	Home	Work	Cell

Emergency Contact Information (Other Than Parent)

Name:	Phone Number:	Relationship to Child:

Insurance Information

Primary Insurance:	
Date Insurance Effective:	Copay Amount:
Policy ID Number:	Group Number:
Subscriber's Name:	Relationship to Patient:
Subscriber's Date of Birth:	Policy Holder's Social Security Number:
Employer:	
Employer Address:	

Secondary Insurance (If Applicable)

Secondary Insurance:	
Date Insurance Effective:	Copay Amount:
Policy ID Number:	Group Number:
Subscriber's Name:	Relationship to Patient:
Subscriber's Date of Birth:	Policy Holder's Social Security Number:
Employer:	
Employer Address:	

Assignment of Insurance Benefits:

I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the patient at this practice.

I understand that my insurance provided, in no way relieves me of financial responsibility for services rendered now or in the future at this practice.

Guarantee of Payment:

I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now or in the future by this practice.

In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33% and 1/3 of the amount due, court costs and reasonable attorney's fees incurred by this practice.

Signature of Parent/ Guardian: _____ Date: _____