

OFFICE USE ONLY: IDX #: _____

CHILD PATIENT INFORMATION

CHART # _____

PATIENT'S NAME: _____
(Last) (First) (M.I.)

S.S. # _____

ADDRESS: _____ ZIP CODE: _____
(Number) (Street) (City) (State)

PATIENT'S SEX: ____ M ____ F PATIENT'S AGE: _____ DATE OF BIRTH: ____/____/____

HOME PHONE: () _____ REFERRING DOCTOR'S NAME: _____

FATHER or GUARDIAN NAME: _____ HOME PHONE: () _____

FATHER or GUARDIAN EMPLOYER: _____ PHONE: () _____

MOTHER or GUARDIAN NAME: _____ HOME PHONE: () _____

MOTHER or GUARDIAN EMPLOYER: _____ PHONE: () _____

PEDIATRICIAN NAME: _____ PHONE: () _____

IN CASE OF EMERGENCY, PERSON TO NOTIFY: _____
(Name) (Relationship) (Phone)

Is child allergic to any medications? ____ Yes ____ No If so, please list: _____

Is child allergic to latex products? ____ Yes ____ No

Please list any medications child is presently taking: _____

METHOD OF PAYMENT AT TIME OF VISIT: ____ CASH ____ CHECK ____ MASTERCARD ____ OTHER ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURED'S NAME: _____ D.O.B. _____ HMO ____ PPO ____
(Please Check if Applicable)

INSURED'S S.S. #: _____ INSURED'S RELATIONSHIP TO PATIENT: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

IF THE POLICY IS THROUGH WORK, PLEASE COMPLETE THE FOLLOWING:
INSURED'S EMPLOYER NAME: _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED'S NAME: _____ D.O.B. _____ HMO ____ PPO ____
(Please Check if Applicable)

INSURED'S S.S. #: _____ INSURED'S RELATIONSHIP TO PATIENT: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

IF THE POLICY IS THROUGH WORK, PLEASE COMPLETE THE FOLLOWING: INSURED'S EMPLOYER NAME: _____

FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY OFFICE VISIT OR PROCEDURES RENDERED BY MY DOCTOR & SFENTA,PA, THAT MY INSURANCE COMPANY DEEMS NOT A COVERED SERVICE UNDER MY POLICY.

DATE: ____ / ____ / ____

SIGNATURE: _____

AUTHORIZATION / RELEASE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any information to my insurance company for the processing of my claims made on the behalf of these service.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS: I hereby authorize my insurance company to issue payment directly to the physicians on my behalf for pending claim(s) due to service rendered to: _____ Relationship to Insured: _____
(Name of Patient)

AUTHORIZATION TO RELEASE INFORMATION TO OTHER PHYSICIAN: I hereby authorize the release of my medical information to my primary care physician: _____
(Name of Doctor)

DATE: ____ / ____ / ____

SIGNATURE: _____