KIDS R GREAT PEDIATRICS

PATIENT INFORMATION SHEET

Patient's Name:______________________________ M/F Age: ____ DOB:____________
(First, MI, Last)

Street Address:______________________________ Phone #:______________________________

City/State/Zip:______________________________________

Siblings/DOB:____

PARENT/GUARDIAN INFORMATION

Mother:____________________________ Father:______________________________
(FULL NAME/DOB) (FULL NAME/DOB)

Address:___________________________ Address:______________________________

Phone #:___________________________ Phone #:______________________________

SSN:_______________________________ SSN:__________________________________

Employer:__________________________ Employer:_____________________________
(Name and Phone Number) (Name and Phone Number)

WHO REFFERED YOU TO OUR PRACTICE? **(Patient's name if know):**______________________________

INSURANCE INFORMATION

PRIMARY

Insurance Name:______________________________

ID/Group #:__________________________________

Subscriber: _________________________________
(Street) (City/State/Zip)

Subscriber SSN: _____________________________

Subscriber phone #:__________________________

Relationship to patient:_____________________

SECONDARY (if applicable)

Insurance Name:______________________________

ID/Group #:__________________________________

Subscriber: _________________________________
(Street) (City/State/Zip)

Subscriber SSN: _____________________________

Subscriber phone #:__________________________

Relationship to patient:_____________________

RESPONSIBLE BILLING PARTY

Name/DOB:____________________________ Address:______________________________

SSN:_________________________________ ______________________________

Relationship to Patient:______________ Phone #:______________________________

I hereby assign, transfer, and set over to Kids R Great Pediatrics, all of my rights, titile and interest to my medical reimbursements benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance . I hereby consent routine diagnostic procedures and medical treatment provided through Kids R Great Pediatrics. I understand that no guarantee of result has been made.

____________________________________ ____________________

Parent/Guardian Signature (Unless over 18) Date