MARYSVILLE PEDIATRICS, INC.

DATE:_____(Please complete both sides of form)

PATIENT INFORMATION

NAME of CHILD:_____
LAST NAME FIRST NAME MIDDLE INITIAL

SEX:____M_____F AGE:____ BIRTHDATE:_____NICK NAME_____

PHONE: ( )_____ SS#_____

ADDRESS:_____
STREET CITY STATE ZIP

PO BOX_____COUNTY_____

PARENT INFORMATION

*******We must have social security numbers(s) for the insurance policy holder********

MOTHER/GUARDIAN NAME:_____

Address:_____

_____

Home Phone:(___)_____Work #:( )_____Cell #: ( )_____

S.S. #:_____Birth date:_____Employer:_____

FATHER/GUARDIAN NAME:_____

Address:_____

_____

Home Phone:(___)_____Work #:( )_____Cell #: ( )_____

S.S.#:_____Birth date:_____Employer:_____

NAMES AND AGES OF PEOPLE IN THE HOUSEHOLD:_____

_____

EMERGENCY CONTACTS (OTHER THAN PARENTS)

NAME:_____RELATIONSHIP:_____PHONE:( )_____

NAME:_____RELATIONSHIP:_____PHONE:( )_____

EMAIL ADDRESS:_____

*********PLEASE COMPLETE THE BACK SIDE*******

INSURANCE INFORMATION

PRIMARY INS:_____**POLICY HOLDER'S NAME:**_____
Policy Holder's D.O.B:_____ID#_____GROUP:_____
Policy Holder's Address:_____
Employer:_____Effective Date:_____
Ins. Company Address:_____

SECONDARY INS:_____**POLICY HOLDER'S NAME:**_____
Policy Holder's D.O.B:_____ID#_____GROUP:_____
Policy Holder's Address:_____
Employer:_____Effective Date:_____
Ins. Company Address:_____

RELEASE AND ASSIGNMENT FOR BILLING

The information that I have given is correct to the best of my knowledge, I understand that it will be held in strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.
I certify that my child is covered by insurance with _____,
(Name of Insurance Company)
and assign directly to Marysville Pediatrics, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic

FINANCIAL RESPONSIBILITY

I agree to pay Marysville Pediatrics, Inc. for services rendered at time of service for my dependent child, or child that I am legally responsible for.

If I have medical insurance I hereby authorize those benefits to be paid directly to Marysville Pediatrics, Inc. I will pay all co-payments at the time of service. I understand that I am responsible for any balance that the insurance does not cover.

If I fail to meet my financial responsibility and it becomes necessary for Marysville Pediatrics, Inc., to turn my account over to an outside collection agency I understand that I will become responsible for any and all fees that Marysville Pediatrics, Inc. will incur as a result of such action. This amount will be due directly to Marysville Pediatrics, Inc. and must be paid prior to any further services with the office.

Accounts can be conveniently paid by cash, personal check or credit card.
Note: There will be a $20.00 charge on each check returned for non-sufficient funds.

If my insurance coverage, personal address or phone numbers change I will promptly notify Marysville Pediatrics,Inc.

_____ _____
PATIENT NAME **RESPONSIBLE PARTY**

_____ _____
WITNESS **DATE**