INFORMATION SHEET (PLEASE PRINT IN ALL CAPITALS)

Patient Name _____ Sex: Male / Female
(LAST) (FIRST) (MIDDLE)

Home Address_____ (Street / Apt. No.)

City _____ State _____ Zip Code _____

Date of Birth (MM/DD/YYYY) _____ Single / Married / Other

Social Security # _____

Home # _____ Work # _____ Cell # _____

Emergency Contact Name _____ Relationship to you _____

Emergency Contact #_____

Patient's Employer _____ Title / Occupation _____

Mother's Name (if child under 18) _____ Mother's Contact # _____

Father's Name (if child under 18) _____ Father's Contact # _____

Spouse's Name _____ Spouse's Contact # _____

Name of person responsible for the bill _____

Address _____

Primary Insurance Company _____

Member # _____ Group # _____

Insured Name_____ (Male / Female)

Insured Date of Birth (MM/DD/YYYY) _____

Your relationship to Insured_____ Insured Employer _____

Do you have Secondary Insurance? YES / NO

Please present all your insurance cards and a Photo I.D. at the front desk when you complete this form. Please read the following paragraph carefully and sign below.

"The information provided above is true and accurate to the best of my knowledge.
I authorize payment directly to Adult and Pediatric Clinic, P.C. for the medical and/or surgical benefits payable to me by my insurance plans. I hereby agree to pay all charges that exceed and/or are not covered by my insurance. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.
I hereby authorize Adult and Pediatric Clinic, P.C. to release information requested by my insurance company or Worker's Compensation Carrier. I also authorize Adult and Pediatric Clinic, P.C. to release information to any hospital or physician I may be referred to by this office. These records may be faxed, mailed or hand delivered."

Signature of the patient or responsible party _____

Today's Date: _____