

PEDIATRIC SOLUTIONS, S.C.

THIS FORM MUST BE COMPLETED IN FULL.

PLEASE PRESENT INSURANCE CARD FOR COPYING AND REMIT COPAY (IF APPLICABLE).

PATIENT INFORMATION—Please Print:

Date: _____

Name (full given name): _____

Address: _____

City, State & Zip Code: _____

Home Phone #: _____ Birth date: _____ Sex: M F

Mother's Name: _____

Cell #: _____ Work #: _____

Mother's Employer: _____ Occupation: _____

Father's Name: _____

Cell #: _____ Work #: _____

Father's Employer: _____ Occupation: _____

Emergency Name & Contact info: _____

(other than above names) _____

Who can we thank for referring you: _____

PRIMARY INSURANCE INFORMATION:

Name of policy holder: _____ Relationship to patient: _____

Address, City, State & Zip (if different from above): _____

Birth date: _____ Social Sec. #: _____

Name of Employer: _____ Phone #: _____

Insurance Co: _____ Group #: _____ Member ID: _____

Does your insurance require a copay? Yes / No How much is the copay?: \$ _____

ON THE DAY OF SERVICE, ALL SELF-PAY PATIENTS ARE RESPONSIBLE FOR ALL FEES. PPO AND HMO PATIENTS ARE RESPONSIBLE FOR ALL COPAYS. PLEASE REMEMBER THAT YOU ARE RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PEDIATRIC SOLUTIONS, S.C.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____