CONTACT INFORMATION

First Name_____Middle_____Last Name_____

Birth Date _____ (circle) M F Nick Name: _____

Primary Address:_____

Primary phone for contact: _____

Primary e-mail for contact: _____

Home Phone: (_____)_____ Other: (_____)_____

Dad Cell: (_____)_____ Mom Cell: (_____)_____

Dad Work: (_____)_____ Mom Work: (_____)_____

Father's Name _____ **Mother's Name** _____

SS#_____ SS#_____

Birthdate _____ Birthdate _____

Address:_____ Address:_____

City:_____ Zip:_____ City:_____ Zip:_____

WRITE SAME if address is SAME as the PRIMARY

PRIMARY INSURANCE

Name of Insurance Co_____ Effective Date _____

Ins. Member ID# _____ Group # _____

Subscriber's Name_____

Mailing Address _____

Birthdate _____ Relationship to Patient _____ **Soc Sec.#:** _____

Employer _____

SECONDARY INSURANCE (Write none, if applies)

Name of Insurance Co_____ Effective Date _____

Ins. Member ID# _____ Group # _____

Subscriber's Name_____

Mailing Address _____

(Birthdate _____ Relationship to Patient _____ **Soc Sec.#:** _____

Employer _____

I understand that, even though I may have some type of insurance and authorize this office to submit charges on behalf of my child, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to my dependent. I am aware that **co-payment is required at each visit**, and if there is no insurance coverage, **payment in full** is required for services provided unless prior payment arrangements have been discussed. I am also aware that there may be procedures or supplies that are not covered by my insurance. I will be responsible for all charges not covered by my insurance. **I will also be responsible for all collection fees, should my account be assigned to a Collection Agency.**

Signature _____Date _____