Patient Information Form

***Patient Information*:**

Last Name _____ First Name _____

Address _____ Date of Birth _____ Sex M____F____

City, State, Zip _____ Phone _____

Social Security # _____-_____-_____ Patient resides with _____

Language:_____ Any Hispanic/Latino Ethnicity? Yes No Race: _____

Responsible Party Information:

MOTHER: Last Name _____ First Name _____ Date of Birth _____ Age _____

Address _____ City, State, Zip _____ Home Phone _____
Cell Phone_____

E-MAIL Address:_____

Social Security # _____-_____-_____ Employer _____

Employer Address _____ Employer Phone _____

FATHER: Last Name _____ First Name _____ Date of Birth _____ Age _____

Address _____ City, State, Zip _____ Home Phone _____
Cell Phone_____

E-MAIL Address:_____

Social Security # _____-_____-_____ Employer _____

Employer Address _____ Employer Phone _____

Emergency Contact: _____ Phone _____ Relationship _____

Preferred Pharmacy & Location:_____

Insurance Information: ***PLEASE COPY ALL APPLICABLE INSURANCE CARDS***

Primary Insurance _____ Secondary Insurance_____

Address _____ Address _____

Policy # _____ Group # _____ Policy # _____Group # _____

Name of Insured _____ Name of Insured _____

Relationship to Patient _____ Relationship to Patient _____

Release of Information

I hereby authorize *Austintown Pediatrics* to submit a claim to my insurance carrier or its intermediaries for all covered services rendered. I authorize and direct my insurance carrier or its intermediaries to issue payment directly to *Austintown Pediatrics*. **I accept full financial responsibility for any personal balance on my account, including but not limited to co-payments, deductibles and services determined as non-covered by my insurance. I agree to pay these amounts at the time services are delivered.** I authorize *Austintown Pediatrics* to release any medical information necessary for payment of my claims.

Signature _____ Date _____