PATIENT INFORMATION

PLEASE PRINT CLEARLY

TODAY'S DATE ____________________

Child's Name: ____
(Last) (First) (Middle)

Date of Birth: ____________ Age: ______ Sex: ___________ Language: _______________ Race: _______________

Address: ____
(City) (State) (Zip)

Home Phone: (______) ______________________ Email: ______________________
(Area Code)
This is used to share important information about your child's care with you

Primary Pharmacy ________________ Address _________________________ Phone __________________

Required:	**Last/First Name**	**Clinic Name**	**Clinic Phone Number**
Primary Care Provider			
Referring Provider *(If different from primary care provider)*			
Any other doctors that are involved in your child's care:			

PARENT / GUARDIAN INFORMATION

Mother/Guardian Name: ____
(Last) (First) (Middle)

D.O.B. _______________ Social Security No.: ______________________ Marital Status: **M S W D SEP**

Employer: ______________________ Business Ph: (_____) _____________ Cell Ph: (_____) _____________
(Area Code) (Area Code)

Home Address (if different from child):____

Father/Guardian Name: ____
(Last) (First) (Middle)

D.O.B. _______________ Social Security No.: ______________________ Marital Status: **M S W D SEP**

Employer: ______________________ Business Ph: (_____) _____________ Cell Ph: (_____) _____________
(Area Code) (Area Code)

Home Address (if different from child): ____

PATIENT INSURANCE / MEDICAL ASSISTANCE INFORMATION

PRIMARY INSURANCE

Insurance Company: ____

Insurance Co. Address: ____

____
(City) (State) (Zip)

Name of Policy Holder: ____

Insurance Group Number: ______________________ **Insurance I.D. Number:** ______________________

SECONDARY INSURANCE:

Insurance Company: ____

Insurance Co. Address: ____

____
(City) (State) (Zip)

Name of Policy Holder: ____

Insurance Group Number: ______________________ **Insurance I.D. Number:** ______________________

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, INCLUDING MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO: PEDIATRIC SURGICAL ASSOCIATES, LTD.
MY CONSENT WILL BE VALID FOR TEN YEARS FROM THE DATE I GIVE IT. I MAY REVOKE MY CONSENT TO SHARE MY INFORMATION IN WRITING AT ANY TIME. REVOKING MY CONSENT DOESN'T APPLY TO INFORMATION THAT HAS ALREADY BEEN SHARED. I UNDERSTAND THAT SOME USES AND SHARING OF MY INFORMATION ARE AUTHORIZED BY LAW AND DO NOT REQUIRE MY CONSENT. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO PURSUE COLLECTIONS FROM THIRD PARTY PAYORS IN MY NAME AND TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNED: ____ DATE: ____________________

Relationship to Patient: ____