Doctor: _____

Adult Patient Information ****required information***

* Name: _____* Date of Birth:_____ *SS#_____

*Address: _____City:_____State:_____Zip:_____

*Primary Phone: _____ Alternate Phone: _____May leave messages at: Prim./Alt./Both
(home/cell) (home/cell)

Parents' Information:

*Mother: _____*SS#:_____ Date of Birth: _____

Address (if different from Patient): _____

*Phone: _____ Employment: _____ Work #:_____

*Father: _____*SS#:_____Date of Birth: _____

Address (if different from Patient): _____

*Phone: _____ Employment: _____ Work#:_____

For additional or extended family members please use reverse side (grandparent, step—parents, etc.)

Emergency contact: [Other than parent] Name: _____ Phone: _____
Relationship to patient: _____

Release of Protected Health Care Information:

I give consent and authorization for the medical, or billing staff of Carmel Pediatrics to discuss my protected Health Care information with the following person(s): [Parents, grandparents, etc.]

_____

_____

Signature (Patient) _____Date_____

Insurance Information:

*Name of Insurance Co.:_____ ID#:_____

*Guarantor name:_____ Insurance Co. Address:_____

Is there a second insurance? Yes/No _____

Additional Insurance Information can be added on reverse side.

Financial Responsibility:

I have verified that all personal information is correct as you have it in my chart. I have verified that the insurance information you have is current. I understand that I could be responsible for payment in full for all services and/or for a $25 fee to re-file to the correct insurance company if I have failed to provide current information and the medical claim is denied by insurance.

I authorize the release of any information acquired during my exam and treatment to be sent to my insurance company for payment of any claims, and authorize payment of medical benefits for services rendered by Martin J. Miller, M.D., Randall D. Stoesz, M.D., Susan L. Davis, M.D. , Carolyn O. Robinson, M.D.

I acknowledge that I have read and understand the Financial Payment Policy for Carmel Pediatrics and have been offered a copy:

***Signature (Patient)**	**Date**	**Signature (Patient)**	**Date**

1/2013 Adult

For Office Use Only: _____ Entered by:_____

Additional Information

Secondary Insurance:

Name of Insurance Co.: _____

I.D. #_____

Guarantor name:_____

Insurance Co. Address:_____

Family members/ contact information:

_____

_____

_____

_____

_____

_____