Doctor: ______________________________________

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#:_________________________

Parents married? Yes/No If divorced, who has legal custody? ____

For additional or extended family members please see reverse side.

Siblings:

Name: _____________________________________Date of Birth: ________________

Name: _____________________________________ Date of Birth: ________________

Name: _____________________________________ Date of Birth: ________________

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

Insurance Information:

Name of Insurance Co.:____ ID#:____

Insured parent's 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 child's chart. I have verified that the insurance information you have for my child 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 child's 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:

***Parent Signature**	**Date**	**Parent Signature**	**Date**

1/2013 Minor

For Office Use Only: ___________ Entered by : ________________

Release of Protected Health Care Information:

{Unless otherwise stated only the Mother and Father may receive medical information}

I give consent and authorization for the medical, or billing staff of Carmel Pediatrics to discuss protected Health Care information about my child with the following person(s):

Name ______________________________ Relationship ____________________ Phone # ______________

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Signature of Parent Date Completed

Additional Information from front side:

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