



Helping Your Children Grow!

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NEW PATIENT FORM

PATIENT					
Name (Last, First, MI)	Social Security - -	Age	Date of Birth	Sex	Home Phone

PARENT / LEGAL GUARDIAN					
Name (Last, First, MI)	Social Security - -	Age	Date of Birth	Sex	Home Phone
Mailing Address		City		State	Zip Code
Employer	City	State	Zip Code	Work Phone	email

INSURANCE INFORMATION				
Primary Insurance Company	Subscriber's Name	Relationship to Child	Policy Number	Copay
	Date of Birth	Social Security - -	Group Number	
Secondary Insurance Company	Subscriber's Name	Relationship to Child	Policy Number	Copay
	Date of Birth	Social Security - -	Group Number	

EMERGENCY CONTACT INFO.			
Name	Relationship	Home Phone	Cell Phone

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT A FEE OR INTEREST, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____ Date: _____
(Signature of insured or authorized person, patient or parent if minor)