How did you hear about our practice? _____

Patient Information

First Name_____ Middle Initial___ Last Name_____

Mailing Address_____City/St/Zip_____

Birth Date_____ Male____Female____ Home# (___) _____

Additional Siblings in Practice

First Name	MI	Last Name	Date of Birth

Primary Insurance

Subscriber's Name _____Date of Birth __Relationship to Patient_____

Employer _____ Member ID _____Group # _____

Name of Insurance _____ Effective Date _____

Secondary Insurance (Write none, if applies)

Subscriber's Name _____Date of Birth _____Relationship to Patient_____

Employer _____ Member ID _____Group # _____

Name of Insurance _____ Effective Date _____

Father's Name _____

Mailing Address _____

City_____ St _____Zip _____

SS # _____ Birthdate _____

Home # (____) _____Work # (____) _____

Cell # (____) _____

Mother's Name _____

Mailing Address _____

City_____ St _____Zip _____

SS # _____ Birthdate _____

Home # (____) _____Work # (____) _____

Cell # (____) _____

- I understand that, even though I may have some type of insurance and authorize this office to submit charges on behalf of my child, I am also responsible for payment. I hereby assign to the doctor, all payments for medical services rendered to my dependent. I am aware **that co payment is required at each visit**, and if there is no insurance coverage, **payment in full** is required for services provided unless prior payment arrangements have been discussed**. I will also be responsible for all collection fees, should my account be assigned to a Collection Agency**.

Signature _____Date_____