Owensboro Pediatrics, PLLC

David E. Danhauer, M.D. John D. Lauzon, M.D.
Michael F. Yeiser, M.D. Lynnette K. Martin, M.D.
Courtney Q. Crews, M.D. Amy H. Ray, M.D.
Andrea P Johnston, M.D.
** Please CIRCLE your doctor's name! **

PLEASE READ FRONT AND BACK CAREFULLY AND COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Child's Name ____ M F Date of Birth ____ / _____/_______

Street Address ____ City___________________ State ____ Zip _______

Child lives with ____
Name(s) and relationship(s) to patient

Names and Ages of Brothers/Sisters ____

Father________ ___________________
Home Phone ( )________________
Mobile Phone ( )________________
SS# ________ –____ – __________
Date of Birth _____ / ____ / ________
Employer ________________________
Work Phone( ) _________________
May we call you at work? ___________

Mother_______________ __________
Home Phone ( )________________
Mobile Phone ( )________________
SS# ________ –____ – __________
Date of Birth _____ / ____ / ________
Employer ________________________
Work Phone( ) _________________
May we call you at work? ___________

In case of Emergency, Please contact ________________________________
Emergency Contact Phone( ) ____________________

Ins. Co____________________________
Subscriber ________________________
Subscribers DOB____/____/_________
Subscribers SSN _____-____-______
Policy # __________________________
Group # __________________________
Copay $_______________
☐ Secondary Ins. Co. (Please Present)
Please present insurance card to Receptionist

Who referred you to us?____

Billing & Authorization to Release Information

IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE RESPONSIBLE FOR ALL BILLS. WE CANNOT BILL THE OTHER PARENT.

Co-payment or applicable deductible is payable for participating insurance plans at time of service. Payment is required at the time of service if uninsured, have a non-participating insurance plan, or for non-covered services, unless prior arrangements have been made.

Occasionally, you may find that some services performed by our office are not covered by your commercial Insurance or Medicaid; these are called "NON-COVERED SERVICES". Examples are services such as Record Transfer Fees, and Monthly Billing Fees for outstanding balances. These services are costly for us to provide and unfortunately, we must charge for them. If you utilize any NON-COVERED SERVICE in this office, you may be billed for it accordingly.

I hereby authorize direct payment of medical/surgical benefits to Owensboro Pediatrics, PLLC for any services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance company.

I hereby authorize Owensboro Pediatrics, PLLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

A photocopy of these assignments shall be as valid as the original.

Parent/Guardian_________________________ Signature ____________________________ Date____ / ___ /_____
(Please Print)

Revised Feb 2009

Owensboro Pediatrics, PLLC

David E. Danhauer, M.D. **John D. Lauzon, M.D.**
Michael F. Yeiser, M.D. **Lynnette K. Martin, M.D.**
Courtney Q. Crews, M.D. **Amy H. Ray, M.D.**
Andrea P Johnston, M.D.

** Please CIRCLE your doctor's name! **

THIS FORM MUST BE COMPLETED BY A PARENT OR LEGAL GUARDIAN

We realize that Parents or Legal Guardians may not always be able to personally bring their child to the office themselves. If a Parent or Legal Guardian cannot be present, then anyone authorized on this form can accompany the child and give consent for treatment.

I, ________________________________ , the Parent or Legal Guardian of________________________________
(Child's Name)
give consent for the following people treated by Drs. David E. Danhauer, Michael F. Yeiser, John D. Lauzon, Lynnette K. Martin, Courtney Q Crews, Amy H. Ray, Andrea P Johnston, and Staff.

Authorized People	Relationship to Patient

I have received a Notice of Privacy Practices from Owensboro Pediatrics, PLLC.

Signature ____ Date _____ /______ / ________

Revised Feb 2009