OWENSBORO Pediatrics

Patient Information

Name (First, Middle, Last): _____

Social Security Number: _____ Date of Birth: _____ Female ___ Male ___

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Email Address: _____

Signature: _____ **Date:** _____
*Signature here allows us to leave a message at the numbers listed via voicemail, person, etc.

List of Siblings

Name: _____ Date of Birth: _____ Male: ____ Female: _____

Name: _____ Date of Birth: _____ Male: ____ Female: _____

Name: _____ Date of Birth: _____ Male: ____ Female: _____

Name: _____ Date of Birth: _____ Male: ____ Female: _____

Name: _____ Date of Birth: _____ Male: ____ Female: _____

Parent/Guardian Information (1)

Name: _____

Date of Birth: _____

SS #: _____

Address: _____

City, State, Zip: _____

Employer: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Email: _____

Relationship to Patient: _____

Marital Status: _____

Parent/Guardian Information (2)

Name: _____

Date of Birth: _____

SS #: _____

Address: _____

City, State, Zip: _____

Employer: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Email: _____

Relationship to Patient: _____

Marital Status: _____

PLEASE TURN OVER

Guarantor/Responsible Party: _____

In case of separated or divorced parents, who is the custodial parent? _____

Primary Insurance Information

Please provide your insurance card to the receptionist

Insurance Company: _____

Subscriber's Name: _____ Date of Birth: _____ SS#: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Information (if applicable)

Please provide your insurance card to the receptionist

Insurance Company: _____

Subscriber's Name: _____ Date of Birth: _____ SS#: _____

Policy Number: _____ Group Number: _____

Emergency Contact Other Than Parent

Name of Contact: _____

Phone Number: _____

Relationship to Patient: Stepparent ____ Grandparent ____ Aunt/Uncle ____ Other: _____

Other Person(s) Allowed to Bring Patient to the Office

Name of Contact: _____

Phone Number: _____ Relationship to Patient: _____

Name of Contact: _____

Phone Number: _____ Relationship to Patient: _____

Name of Contact: _____

Phone Number: _____ Relationship to Patient: _____

Private Insurance Authorization for Assignment of Benefits/Information Release

I, the undersigned, authorize payment of medical benefits to Owensboro Pediatrics for any services furnished to me by the physicians. I understand that I am financially responsible for any copays, coinsurance, deductibles, non-covered services, and percentages that are not covered by my contract at time of service. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims of benefit.

_____ _____

Signature **Date**