FAMILY INFORMATION SHEET

PLEASE LIST ALL OF YOUR CHILDREN'S NAMES

CHILD'S NAME (FIRST/MIDDLE/LAST)	**SSN**	**SEX**	**BIRTHDATE**
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

HOME PRIMARY
ADDRESS _____APT_____ PHONE (____)_____
CITY/STATE/ZIP _____

FATHER'S NAME_____**SSN**_____
ADDRESS (IF DIFFERENT)_____PHONE(____)_____
CITY/STATE/ZIP_____CELL PHONE(____)_____
EMPLOYER_____
JOB TITLE_____WORK PHONE(____)_____

MOTHER'S NAME_____**SSN**_____
ADDRESS (IF DIFFERENT)_____PHONE(____)_____
CITY/STATE/ZIP_____CELL PHONE(____)_____
EMPLOYER_____
JOB TITLE_____WORK PHONE(____)_____

PERSON(S) RESPONSIBLE FOR THE BILL: _____

IF PARENTS ARE DIVORCED, WHICH PARENT HAS CUSTODY? _____

- In the event all or any portion of the balance due becomes past due, and person listed as responsible for payment on the account accepts responsibility for the full amount past due.
- Payment made by check/credit card is subject to a service fee of $20.00 per item in the event the check/credit card is returned as a stop payment item.
- I (We) have read and agree to abide by the financial policies of Pediatric and Adolescent Care, LLP.
- I (We) hereby give authorization to the physicians and staff of Pediatric and Adolescent Care, LLP, to treat my child(ren) with reasonable and proper medical care by today's standards if I cannot be reached for verbal authorization.

SIGNATURES:

FATHER _____ DATE_____

MOTHER_____ DATE_____

LIST THE NAMES AND PHONE NUMBERS OF TWO RELATIVES OR FRIENDS WHOM WE MAY CONTACT IN CASE OF EMERGENCY

NAME_____RELATION_____PHONE_____
NAME_____RELATION_____PHONE_____

REFERRED TO THIS OFFICE BY_____

BUSINESS OFFICE USE ONLY – Updated By _____Date_____

PLEASE COMPLETE THE REVERSE SIDE

INSURANCE INFORMATION

THIS FORM MUST BE UPDATED ANNUALLY OR WHENEVER THERE IS A CHANGE OF INSURANCE IN ORDER TO MAINTAIN A VALID AUTHORIZATION TO FILE YOUR INSURANCE. A COPY OF YOUR INSURANCE CARD(S) MUST BE ATTACHED TO THIS FORM.

INSURANCE COMPANY_____
CLAIMS ADDRESS_____
SUBSCRIBER'S NAME_____**DOB**_____
ID#_____GROUP#_____
EMPLOYER_____
OFFICE COPAY_____**EFFECTIVE DATE**_____
RELATIONSHIP TO PATIENT(S)_____

COMMUNITY CARE HMO ONLY: WHICH HOSPTIAL NETWORK? ST. JOHN_____ ST. FRANCIS_____

I hereby authorize the release of any medical or other information necessary to process claims for services provided by this practice. I also authorize payment directly to my physician of the physician's benefits otherwise payable to me but not to exceed my indebtedness to said physician. I understand I am financially responsible to the physician for charges not covered by this agreement. A copy of this assignment is as valid as the original.

PRIMARY HOLDER'S SIGNATURE_____DATE_____