Patient Information Form

Pls print clearly so that we can process your information quickly and efficiently. Thank you!

Patient Full Name: (Last, M.I, First) ____

Date of Birth: ______________________ **Sex:** ________ **Patient's SSN:** ______________

Mother's Maiden Name: __________________________

Address: ____

Phone Number: __________________________ (Circle One) **Work Home Cell**

Ethnicity (Circle One): **Hispanic Non-Hispanic** **Race:** ______________________________

Email: ____

Emergency Contact Name: ____

Emergency Contact's Relationship to patient: ______________________________________

Emergency Contact's Phone Number: ____

Guarantor Name (Person responsible for bill): ______________________________________

Guarantor's Date of Birth: ____________________ **Sex:** ______________________

Guarantor's SSN: __________________**Relationship to Patient:** ______________________

Guarantor's Address (If different from the patient):___________________________________

____

Insurance Name: ____

Subscriber's Name: ______________________________________

Subscriber's Date of Birth: __________________________________

Subscriber's Insurance ID: __________________________________

Member's ID: ____________________ **Group ID:** ________________________

Preferred Pharmacy (Address, Phone Number and/or Cross Street):

____

PLEASE READ CAREFULLY, INITIAL, AND SIGN AS INDICATED:

I AUTHORIZE Acclaim Pediatrics to render medical care to my child ________. I AUTHORIZE Acclaim Pediatrics to file my health insurance and ASSIGN any benefits payable to Acclaim Pediatrics________. I UNDERSTAND AND ACKNOWLEDGE that I am ultimately responsible for any fees incurred for services provided to my child (regardless of insurance status). Patient responsibility amounts are due in full at the time services are provided. This may include but is not limited to co-payments, co-insurance or account balances ________. I UNDERSTAND AND ACKNOWLEDGE that if I do not have insurance, I am responsible for any fees incurred for services rendered ________. I AGREE AND ACKNOWLEDGE that it is my responsibility to notify Acclaim Pediatrics immediately of any changes in my insurance ________.

Signature: ______________________ **Relationship:** __________________ **Date:** ____________