

CONFIDENTIAL PATIENT INFORMATION

PATIENT# _____ DATE _____

PATIENT'S NAME & DATE OF BIRTH _____

SEX _____

CHILD #1 _____ DOB _____ M _____ F _____

CHILD#2 _____ DOB _____ M _____ F _____

CHILD#3 _____ DOB _____ M _____ F _____

CHILD#4 _____ DOB _____ M _____ F _____

PATIENT'S ADDRESS _____ APT _____

CITY _____ STATE _____ ZIP CODE _____ PH# _____

RESPONSIBLE PARTY

NAME & ADDRESS _____

RELATIONSHIP _____ HM PH# _____ CELL PH# _____

EMERGENCY CONTACT NAME & PH# _____

INSURANCE PRIMARY

POLICY HOLDER _____ SS# _____ / _____ / _____ DOB _____ / _____ / _____

INS CO NAME _____ EFFECTIVE DATE _____

EMPLOYER _____ WORK # _____

ID# _____ GRP# _____ COPAY _____

CLAIMS MAILING ADDRESS _____

PH# _____

SECONDARY INSURANCE

POLICY HOLDER _____ SS# _____ / _____ / _____ DOB _____ / _____ / _____

INS CO NAME _____ ID# _____ GRP _____

EMPLOYER _____ WORK # _____

CLAIMS ADDRESS _____ PH _____

I authorize payment of medical benefits to Northern Kentucky Pediatric Group for medical services rendered by them. I authorize the release of any information to process insurance claims or secure payment. A photocopy of this authorization is to be considered as original. This authorization will remain in effect until revoked by me in writing

Signed _____ Date _____

Parents who carry insurance should know all professional services furnished are charged directly to the responsible party, who is personally responsible for payment. We will take all necessary steps to collect payments from your insurance company. However, we cannot render services on the assumption that our claims will be paid by the insurance company. Misunderstandings about coverage can be avoided if you know what your policy covers.

PLEASE READ CAREFULLY AND SIGN _____