

PATIENT NAME: _____
Last First Middle

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ SEX: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL PHONE #: _____

RESPONSIBLE PARTY (Parent or legal guardian who resides with patient)

NAME: _____
Last First Middle

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ SEX: _____

MARITAL STATUS: Married Single Divorced Widowed Separated Domestic Partner

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ DRIVER'S LICENSE #: _____

EMPLOYER: _____ EMPLOYER PHONE #: _____

EMERGENCY CONTACT: _____ PHONE #: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

RESPONSIBLE PARTY'S SPOUSE

SPOUSE'S NAME: _____ SPOUSE'S SS#: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S D.O.B.: _____

INSURANCE INFORMATION

INSURANCE CO.: _____ INSURED: _____

ID#: _____ GROUP: _____

CO-PAY AMOUNT: _____ DEDUCTIBLE: _____

PLEASE SIGN AND RETURN TO RECEPTIONIST:

I/we (parent or legal guardian) do hereby consent to and authorize the performance of all treatments, surgery and medical/behavioral health services by the staff of Becker Pediatrics which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I hereby authorize my insurance benefits to be paid directly to Becker Pediatrics and the release of any information required to process a claim. I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage.

I furthermore agree to pay legal interest, collection expense, and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Becker Pediatrics to release information requested by insurance company and/or it's representative. I fully understand that the agreement and consent will continue until cancelled by me in writing.

Please sign: _____ Date: _____