



# Patient Information Form

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Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

How did you hear about our office?  Established Patient / Friend / Neighbor  Yellow Pages  Insurance Co.  Walk-in

Name of Mother: \_\_\_\_\_

Street Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Drivers License No: \_\_\_\_\_

Name of Father: \_\_\_\_\_

Street Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Drivers License No: \_\_\_\_\_

## Primary Insurance Information

Insured Name: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Policy ID: \_\_\_\_\_

## Secondary Insurance Information

Insured Name: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Policy ID: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

List name, sex and birth date of all siblings: \_\_\_\_\_

\_\_\_\_\_

Please bring patient's insurance card to every visit. Parents/Guardians are responsible for notifying our office of changes of address and/or insurance coverage. Please note that whomever brings the patient(s) to their appointment is responsible for paying the Insurance Co-pay if applicable. When writing a personal check, please have Drivers License or State ID available.

**Authorization To Release Medical Information:** I hereby authorize St. Clair Pediatrics to release any information acquired in the course of my examination or treatment to any insurance company against which claims are filed on my behalf. I hereby authorize payments directly to St. Clair Pediatrics of the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for payment of all charges for services rendered and that if my insurer fails to pay any portion of these charges for any reason, I will be responsible for all sums due St. Clair Pediatrics. If my account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

Date of Birth: \_\_\_\_\_

Gender:  Male  Female

Primary Care Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Copay: \_\_\_\_\_ Preventive Coverage?  Y  N

Group Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Copay: \_\_\_\_\_ Preventive Coverage?  Y  N

Group Number: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_