FAMILY/PATIENT INFORMATION SHEET – 2014

MOTHER'S INFORMATION

Name:____
Last First Middle Initial

Home Address:____
Street City State Zip Code

PREFERRED CONTACT NUMBER (circle one): HOME / MOM'S CELL / DAD'S CELL

Home Phone #: (_____)_________________________ County: _____________________

Work Phone #: (_____)_________________________ Cell Phone #: (_____)_________________________

Date of Birth: Month_______ Day_______ Year________ Social Security #_______________________

Marital Status (circle one): Married Divorced Separated Widowed Single

Employer:_____________________________________Occupation:_____________________________________

Who may we thank for referring you? ____

Email Address: ____

FATHER'S INFORMATION

Name:____
Last First Middle Initial

Home Address:____
Street City State Zip Code

Home Phone #: (_____)_________________________ County: ______________________

Work Phone #: (_____)_________________________ Cell Phone #: (_____)_________________________

Date of Birth: Month_______ Day_______ Year________ Social Security # _______________________

Marital Status (circle one): Married Divorced Separated Widowed Single

Employer:_____________________________________Occupation:_____________________________________

Email Address: ____

Child:____
First Name Middle Initial Last Name Birthdate

Child:____
First Name Middle Initial Last Name Birthdate

Child:____
First Name Middle Initial Last Name Birthdate

Child:____
First Name Middle Initial Last Name Birthdate

PLEASE COMPLETE BACK OF FORM →

PATIENT EMERGENCY CONTACT (NOT LIVING WITH PATIENT)

Name:_______________________________________ Phone Number: (   )______________________

Address:____________________________________ City:___________________________________

State:_______________ Zip Code:________________ Work Phone Number:______________________

Relationship to Patient:____

FINANCIAL ARRANGEMENTS AND INSURANCE

Co-payments are due at the time services are rendered. We accept cash, check, MasterCard, Visa and Discover.

If you have medical insurance, Arlington Pediatrics, Ltd. will submit claims directly to your insurance company. Your insurance is a contract between you, your employer and the insurance company. Arlington Pediatrics, Ltd. is not a party to that contract. Not all services are a covered benefit in all contracts, and it is your responsibility to be aware of what benefits your insurance entitles you to. We will assist you to receive your maximum allowable benefits.

We emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your patient due balance. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account.

By signing below, I agree and understand all of the above statements regarding financial arrangements and insurance. I authorize payment of medical benefits directly to Arlington Pediatrics, Ltd.

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Signature of Parent/Guardian ***Date***

AUTHORIZATION TO TREAT

We recognize there may be occasions when neither parent (or guardian) is available to bring their child(ren) to our office. Your signature below will allow us to provide care for your child(ren) in your absence. Otherwise we will need to obtain your written permission prior to caring for your child(ren) for each occasion of your absence.

I authorize the doctors of Arlington Pediatrics, Ltd. to provide medical care and treatment for my child(ren) in my absence, including but not limited to routine examinations, immunizations and lab tests.

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Signature of Parent/Guardian ***Date***