

Patient Information Sheet

**\*\*In order to contain costs, we expect copays at the time of service.\*\***

**PATIENT INFORMATION**

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Last Name	First	M.I.	Sex	Date of Birth
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Address	City	State	Zip
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Home Phone	Primary Physician	Referred By
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Fathers Name	Birth Date	Social Security No.	Employer	Work #
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Mother's Name	Birth Date	Social Security No.	Employer	Work #
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\_\_\_ I want to be contacted regarding appointments by: Phone or Cell # \_\_\_\_\_ Email \_\_\_\_\_

\_\_\_ Medical Information will be given to those circled: Mother Father Other/Relationship \_\_\_\_\_

**EMERGENCY CONTACT (OTHER THAN PARENT)**

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Name	Relationship	Telephone # or Cell #
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**INSURANCE INFORMATION** *If no copy of insurance card available, account will be considered "self-pay".*

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Primary Insurance Company	Subscriber	Employer/Group Name
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Secondary Insurance Company	Subscriber	Employer/Group Name
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**Medical Authorization:** The undersigned permits the physicians of this practice and all other personnel caring for my child to examine, recommend treatment, and explain any associated risk involved. The undersigned also understands that this care may include diagnostic testing, examinations, or surgical treatment and no guarantees have been made regarding the outcome of this care. In the event of my absence, I authorize Child Care Limited to provide any necessary treatment to my child.

**Financial Agreement:** The undersigned agrees to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by Child Care Limited on my behalf, negotiating payments through my insurance company ultimately is my obligation. I understand that amounts billed to insurance become past due after 45 days and are my responsibility. If I have no insurance, I understand that payment will be made at the time the services are rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me showing the balance due from me and will be considered past due after 30 days. If I am unable to make payment in full I understand that I should call the billing department immediately to set up a payment arrangement. I understand that if no payment has been received or financial arrangements made on my balance, my account may be sent for collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as any fees involved in the collection process.

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Signature	Date
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