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2013

Chart #: _____________

Date Entered: ___/____/20___

Nov-12

PATIENT INFORMATION:

Patient Name: ______________________________ **Today's Date:** ____ / ____ / ____

(Last) (First) (Middle)

Address: ______________________________ **Home Phone** ______________

____

Birth Date: ____ / ____ / ____ **Social Security #:** ______-____-________ **Sex:** ( ) Male ( ) Female

School or Day Care: ______________________________

PARENT/GUARDIAN INFORMATION:

Name: ______________________________ **Relation:** ______________

(Last) (First) (M.)

Address: ______________________________ **Home Phone:** ______________

(if different from patients) ______________________________ **Work Phone:** ______________

Social Security Number: ______________ **Parent/Guardian's Date of Birth:** ______________ **Cell Phone:** ______________

Email Address: ______________________________ **Other Phone:** ______________

Employer: ______________________________ **Does Parent/Guardian Smoke?** ___ **yes** ___ **no**

Name: ______________________________ **Relation:** ______________

(Last) (First) (M.)

Address: ______________________________ **Home Phone:** ______________

(if different from patients) ______________________________ **Work Phone:** ______________

Social Security Number: ______________ **Parent/Guardian's Date of Birth:** ______________ **Cell Phone:** ______________

Email Address: ______________________________ **Other Phone:** ______________

Employer: ______________________________ **Does Parent/Guardian Smoke?** ___ **yes** ___ **no**

BROTHERS & SISTERS OF PATIENT:

	Last Name	First Name	Middle Name	Birthday
1				____ / ____ / ____
2				____ / ____ / ____
3				____ / ____ / ____
4				____ / ____ / ____

IMPORTANT FAMILY INFORMATION:

Does the patient live with both biological parents? ___yes ___no (if no please explain)

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: ______________________ **I. D. #:** ______________

Company Address: ______________________ **Group #:** ______________

____

Patients Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other: ______________________

Insured's Sex: ( ) Male ( ) Female **Insured's Date of Birth:** ____ / ____ / ____

Insured's Name: ______________________ **Insured's Social Security #:** ______________

Insured's Address: ______________________

Please present all your insurance cards to the receptionist at every visit. Thank you!

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: ______________________ **I. D. #:** ______________

Company Address: ______________________ **Group #:** ______________

____

Patients Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other: ______________________

Insured's Sex: ( ) Male ( ) Female **Insured's Date of Birth:** ____ / ____ / ____

Insured's Name: ______________________ **Insured's Social Security #:** ______________

Insured's Address: ______________________

Please present all your insurance cards to the receptionist at every visit. Thank you!

SIGNATURES

______ I authorize the release of any medical information necessary to process insurance claims filed on my behalf:

______ I authorize payment of medical benefits to be made directly to the supplier or physician for services performed:

______ I have received a copy of Dr. Bailey's "Notice of Privacy Practices" (4/14/2003) as required by the HIPAA regulations.

______ I understand as guarantor, it is my responsibility to provide **all** insurance carrier(s) information needed for billing. I understand, as guarantor, if I do not provide **all** insurance carrier(s) information, I will be liable for any balances not paid by my insurance carrier(s).

______ I understand that I am responsible for my bill and that I will pay **all** charges not covered by insurance.

______ I understand that an interest charge will be added to **all** accounts that are 60 days past due.

______ I understand that typing my name or initials into the Electronic Medical Records (EHR) here at the office is the same as if I were signing a paper form.

______ I also understand that checking a box in the EHR gives my permission for treatment/procedures.

______ I understand and give permission for information to be left on my answering machine or voice mail concerning appointments, normal lab results and requests to call the office back.

Guarantor on this account: ______________________

Print Patient's Name: ______________________

Insured's Signature: ______________________

Relationship: ______________________ **Date:**

SPECIAL PERMISSION:

Please list anyone who will need to bring this child to the doctor besides the parents/guardians on a regular basis. We must have the exact name that would appear on a picture ID such as a drivers license.

Name: ______________________ Relation to Child ______________

Address: ______________________ Phone: ______________

Name: ______________________ Relation to Child ______________

Address: ______________________ Phone: ______________

Parents/Guardians Signature: ______________________ **Date:** ______________

Notary Public, State at Large: ________________________ Commission Expires:___/___/___ Date___/___/___