

PEDIATRIC PATIENT INFORMATION SHEET

Patient Information

PATIENT NAME _____ DATE OF BIRTH ____ / ____ / ____
First Middle Last

HOME ADDRESS _____
Street City State Zip

COUNTY OF RESIDENCY _____ NAME YOU PREFER TO BE CALLED _____

HOME TELEPHONE (____) _____ SEX M F SOCIAL SECURITY # _____
(Circle One)

PARENTS' NAMES _____

FATHER'S CELL PHONE (____) _____ MOTHER'S CELL PHONE (____) _____

FATHER EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ TELEPHONE (____) _____
Street City State Zip

MOTHER EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ TELEPHONE (____) _____
Street City State Zip

NAME OF CONTACT PERSON IN CASE OF EMERGENCY, OTHER THAN NAMES LISTED ABOVE _____

TELEPHONE OF CONTACT (____) _____ RELATIONSHIP TO PATIENT _____

REFERRED BY _____

GUARANTOR NAME _____ GUARANTOR A PATIENT HERE? Y or N
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT) (Circle One)

ADDRESS _____
Street City State Zip

TELEPHONE NUMBER (____) _____ RELATIONSHIP TO PATIENT Self Spouse Parent
(Circle One) Step-Child Other _____

CELL PHONE NUMBER (____) _____

Primary Coverage

Insurance Information

PRIMARY INSURANCE COMPANY _____

POLICY OWNER'S NAME _____ DATE OF BIRTH ____ / ____ / ____

POLICY OWNER'S PLACE OF EMPLOYMENT _____

INSURANCE ID NUMBER _____ EFFECTIVE DATE

GROUP NUMBER _____ / /

INSURANCE ADDRESS _____
Street City State Zip

TELEPHONE NUMBER (____) _____ RELATIONSHIP TO PATIENT Self Spouse Parent
(Circle One) Step-Child Other _____

(OVER, Please)

Secondary Coverage

Insurance Information

SECONDARY INSURANCE COMPANY _____

POLICY OWNER'S NAME _____ DATE OF BIRTH ____/____/____

POLICY OWNER'S PLACE OF EMPLOYMENT _____

INSURANCE ID NUMBER _____ EFFECTIVE DATE

GROUP NUMBER _____ / /

INSURANCE ADDRESS _____

Street

City

State

Zip

TELEPHONE NUMBER () _____

RELATIONSHIP TO PATIENT Self Spouse Parent
(Circle One) Step-Child Other _____

Important Patient Information & Authorization

In order to keep costs down, the physician sees patients on a fee for service basis only, and we expect payment at the time of service. We try to assist you in submitting your insurance claims by providing you with a detailed receipt form at the end of each visit that contains all the information needed from the doctor for your insurance company to process your claim.

Valley Health Center requires 24-hours notice of cancellation if an appointment needs to be changed so that we may provide appointment time for patients who need it. There will be a \$50.00 charge for missed appointments.

I authorize Valley Health Center to release any information to my insurance carriers concerning my medical treatments. I also authorize payment to be made directly to Valley Health Center if not already paid in full by the insured. Valley Health Center reserves the right to charge 2% interest per month on any unpaid balance.

I hereby certify to the above statements and agree to be financially responsible for any payments not covered by insurance.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: ____/____/____