



Under 18 or full-time student under age 22

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED. (PRINT AND PRESS HARD.)

INSURANCE AUTHORIZATION AND ASSIGNMENT

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PLEASE SIGN BY BOTH X'S

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.

X Signed (Insured or Authorized Person)

I authorize the release of any medical information necessary to process this claim and all future claims.

X Signed

CHILD INFORMATION

Form fields for child information including Last Name, First Name, Middle Initial, Nickname, Street Address, City, State, Zip, Sex, Date of Birth, Home Phone, Soc. Sec. No., Is the Child currently employed?, Work Phone, Ext., Occupation, Is the Child a student?, and FATHER'S DATE OF BIRTH and MOTHER'S DATE OF BIRTH.

PARENT OR GUARDIAN INFORMATION

Form fields for parent or guardian information including Last Name, First Name, Middle Initial, Relationship to Child, Street Address, City, State, Zip, Employer, Occupation, Work Phone, Ext., Soc. Sec. No., and Is the Parent/Guardian? (Single, Married, Separated, Divorced, Widowed).

If you circled Married, please complete Spouse information below.

Form fields for spouse information including Spouse's Last Name, First Name, Middle Initial, Nickname, Soc. Sec. No., Is Spouse employed?, Work Phone, Ext., and Occupation.

REFERRING PHYSICIAN

Form fields for referring physician including Who is the Child's Referring Physician?, First Name, Last Name, Phone, and Is the Child's Primary Care Physician the same? (Yes/No).

NEXT OF KIN INFORMATION

Form fields for next of kin including Give the name of nearest relative or of a close friend not living with child, to contact in case of an emergency, Name, Home Phone, Work Phone, Relationship, City, and State.

INSURANCE INFORMATION

In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be completely filled out.

Form fields for insurance information including Does the Child have health insurance? (Yes/No), Medicare Number, Medicaid State ID Number, Is this visit related to a work injury? (Yes/No), Date of Injury, Is this visit related to an auto accident? (Yes/No), Date of Accident, and Please show your ID card to the receptionist.

Form fields for CHILD'S HEALTH INSURANCE including Insurance Company, Ins. Co. Address, City, State, Zip, Policy Holder (First Name, Middle Initial, Last Name), Social Security Number, Employer, and Group No. ID No.

Form fields for CHILD'S OTHER INSURANCE (Secondary Health, Worker's Comp. or Auto Ins.) including Insurance Company, Ins. Co. Address, City, State, Zip, Policy Holder (First Name, Middle Initial, Last Name), Social Security Number, Employer, and Group No. ID No.

OFFICE POLICY