

Patient Information Form

Date: _____



Primary Doctor
_____ Dr. Bonnett
_____ Dr. Shealy
_____ Dr. Thompson

PLEASE PRINT LEGIBLY

GENDER: Male Female Race: _____

FULL NAME (LAST) _____ (FIRST) _____ (M.I.) _____

DATE OF BIRTH: (mm/dd/yy) _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ (9 Digit)

MOTHER'S NAME: _____ DOB: _____ SS#: _____

MOTHER'S ADDRESS: _____ STATE: _____ ZIP CODE _____

HOME #: _____ CELL #: _____ EMAIL: _____

MOTHER'S EMPLOYER: _____ WORK #: _____ EXT. _____

FATHER'S NAME: _____ DOB: _____ SS#: _____

FATHER'S ADDRESS: _____ STATE: _____ ZIP CODE _____

HOME #: _____ CELL #: _____ EMAIL: _____

FATHER'S EMPLOYER: _____ WORK #: _____ EXT. _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS PATIENT? MOTHER _____ FATHER _____ OTHER (NAME) _____

EMERGENCY CONTACT (Non Parent): _____ PHONE #: _____

PRIMARY INSURANCE INFORMATION	
Insurance Company:	_____
Policy #:	_____
Group #:	_____
Subscriber Name:	_____
S.S. #:	_____ Date of Birth: _____
Relationship to Patient:	_____

SECONDARY INSURANCE INFORMATION	
Insurance Company:	_____
Policy #:	_____
Group #:	_____
Subscriber Name:	_____
S.S. #:	_____ Date of Birth: _____
Relationship to Patient:	_____

PRIVACY INFORMATION:

- 1) I hereby authorize Chapin Pediatrics, PA to furnish information to my insurance carrier(s) concerning the above patient's illness or treatment. I hereby assign to the physician all payment for medical services rendered to my dependent or to myself. I understand that I am responsible for any amount not covered by my insurance company. I authorize use of a copy of this assignment in lieu of the original when necessary. I understand that my information is stored on a computer and that the information may be relied upon by others to provide the patient with medical care.
- 2) I understand that all after hour calls beginning April 1, 2008 will incur a \$20.00 fee when speaking to an after hours clinical professional. I understand that I am responsible for this fee since my insurance company will not cover it.
- 3) May we leave medical information messages on your answering machine or voice mail? Yes _____ No _____
- 4) _____ I acknowledge that Chapin Pediatrics, PA has allowed me to review their Notice of Privacy Practices.
- 5) _____ I acknowledge that Chapin Pediatrics, PA has allowed me to review their Financial Policy.

I HAVE READ AND AGREE TO THE ABOVE OFFICE POLICIES

PARENT/GUARDIAN NAME _____ PARENT/GUARDIAN SS# _____
(Please Print)

PARENT/GUARDIAN SIGNATURE (must be legible) DATE