Welcome to the
CHILDREN'S CLINIC OF PASCAGOULA

(PLEASE PRINT CLEARLY)

PATIENT INFORMATION:

CHILD'S NAME ____________________

NICKNAME ____________________ SEX ______

BIRTHDATE ____________________ AGE ______

SOC. SEC. # ____________________

SCHOOL ____________________ GRADE ______

CHILD'S HOME ADDRESS ____________________

CITY ____________ STATE ______ ZIP ________

PHONE # ____________________

RESPONSIBLE PARTY:

NAME ____________________

RELATIONSHIP ____________________

ADDRESS ____________________

CITY ____________ STATE ______ ZIP ________

SOC. SEC. # ____________________

BIRTHDATE ____________________

MOTHER ❒
STEPMOTHER ❒ OTHER ❒
GUARDIAN ❒

NAME ____________________

HOME PHONE ____________________

ALTERNATE PHONE # ____________________

WORK PHONE ____________________

EMPLOYER ____________________

OCCUPATION ____________________

SOC. SEC. # ____________________

BIRTHDATE ____________________

MAIDEN NAME ____________________

FATHER ❒
STEPFATHER ❒ OTHER ❒
GUARDIAN ❒

NAME ____________________

HOME PHONE ____________________

ALTERNATE PHONE # ____________________

WORK PHONE ____________________

EMPLOYER ____________________

OCCUPATION ____________________

SOC. SEC. # ____________________

BIRTHDATE ____________________

❒ Married ❒ Single ❒ Divorced

• PLEASE COMPLETE THE BACK OF THIS FORM •

PRIMARY INSURANCE	ADDITIONAL INSURANCE
Insured's Name_______________	Insured's Name_______________
Relationship_______________	Relationship_______________
Birthdate_______________	Birthdate_______________
Soc. Sec #_______________	Soc. Sec #_______________
Employer_______________	Employer_______________
Occupation_______________	Occupation_______________
Insurance Co._______________	Insurance Co._______________
Effective Date_______________	Effective Date_______________
Group #__________ID#__________	Group #__________ID#__________
Deductible__________CoPay______	Deductible__________CoPay______
Amount already used__________	Amount already used__________
Max. Annual benefit__________	Max. Annual benefit__________

Name of person to be contacted in case of emergency and authorization to disclose confidential information (billing/payments; treatment; and protected health information:

Name ______________________ **Phone:** ______________________

______________________ ______________________

______________________ ______________________

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and the records of any treatments rendered to my child during the period of such care to the names listed above, third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

LATE CHARGES

I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this amount, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE