

PEDIATRIC PATIENT DEMOGRAPHICS

Last Name _____ First Name _____ Middle _____

Address _____ City _____ ST _____ Zip _____
(No post office boxes)

Home phone (____) _____ - _____ Emergency contact name _____

Phone (____) _____ - _____

Male Female Date of birth ___/___/___ Age _____ SSN _____ - _____ - _____

Mother's last Name _____ First _____ Middle _____

Employer _____ Work phone (____) _____ - _____

Father's last Name _____ First _____ Middle _____

Employer _____ Work phone (____) _____ - _____

Legal Custody: Joint (married) _____ Joint (divorced) _____ Mother _____ Father _____

*** How did you hear about our practice?**

Referring Physician _____	Primary Physician _____
Phone (____) _____ - _____	Phone (____) _____ - _____
Address _____	Address _____

***Primary verification (for office use only)** _____

Insurance company _____ Phone number _____

Policy number _____ Group number _____

Policy holder _____ Relationship to patient _____

SSN _____ - _____ - _____ DOB ___/___/___ Employer _____

Patient Agreement

I, the undersigned, am aware that I am financially responsible for all services rendered to me by - Feldman Oringher Dettelbach Mesick & Schoenfeld Otolaryngology, P.C. (the practice)

For those insurances for which the practice accepts assignment,

I am aware that I am personally responsible for all co-payments, deductibles, and non-covered services. As dictated by my insurance coverage.

I, the undersigned, hereby authorize Feldman Oringher Dettelbach Mesick & Schoenfeld Otolaryngology, P.C. (the practice) to apply for benefits for covered services rendered by the Practice, and request that the payments from my insurance carrier and/or Medicare part B be paid directly to the Practice.

I certify that the information I have provided with regard to my identity and insurance coverage is correct, and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier(s) (or in the case of Medicare part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

I, the undersigned, am aware that if at any time my account is sent to an outside collection agency I will be responsible for payment of an additional 30% of the amount sent.

I, the undersigned, am aware that I will be charged a \$25.00 no-show fee for any appointment I cancel without a twenty four (24) hr notice

Signature _____ Date _____
(Parent/guardian)

Account # _____