WEST BROWARD PEDIATRICS PATIENT INFORMATION SHEET

DATE:_____ PRIMARY LANGUAGE SPOKEN:_____

LIST ALL CHILDREN IN THE FAMILY

FIRST	MIDDLE	LAST	DOB	GENDER
_____	_____	_____	____/____/_____	_____
_____	_____	_____	____/____/_____	_____
_____	_____	_____	____/____/_____	_____
_____	_____	_____	____/____/_____	_____

HOME STREET ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE: _____

CHILDREN LIVE WITH: _____PARENT/GUARDIAN #1 _____PARENT/GUARDIAN #2 _____BOTH

PARENT/LEGAL GUARDIAN RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATIONS:

PARENT/LEGAL GUARDIAN #1 (OR PATIENT IF 18 YEARS OR OLDER)

FIRST NAME: _____MIDDLE INITIAL:_____ LAST NAME: _____

RELATIONSHIP TO PATIENT: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH (MM/DD/YYYY) _____/_____/_____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

STREET ADDRESS (IF DIFFERENT FROM ABOVE): _____

CITY:_____ STATE:_____ ZIP CODE:_____

EMPLOYER NAME: _____OCCUPATION:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

WORK PHONE: _____EXT_____

PARENT/LEGAL GUARDIAN #2

FIRST NAME: _____MIDDLE INITIAL:_____ LAST NAME: _____

RELATIONSHIP TO PATIENT: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH : (MM/DD/YYYY) _____/_____/_____

HOME PHONE:_____ CELL PHONE: _____

EMAIL ADDRESS: _____

STREET ADDRESS (IF DIFFERENT FROM ABOVE): _____

CITY:_____ STATE:_____ ZIP CODE:_____

EMPLOYER NAME: _____ OCCUPATION:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP CODE: _____

WORK PHONE: _____EXT_____

(CONTINUE TO PAGE TWO)

NEAREST RELATIVE OR EMERGENCY CONTACT:

FIRST NAME:_____ LAST NAME:_____

RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ CELL PHONE:_____

REFERRED BY: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

ADDRESS: _____CITY: _____STATE:_____ ZIP:_____

PHONE NUMBER:_____

HEALTH INSURANCE INFORMATION

INSURANCE COMPANY:_____

INSURANCE COMPANY PHONE #:_____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S EMPLOYER: _____

SUBSCRIBER'S DATE OF BIRTH: (MM/DD/YYYY)_____/_____/_____

SUBSCRIBER'S SOCIAL SECURITY #:_____

ID/POLICY #:_____

GROUP #:_____

EFFECTIVE DATE: (MM/DD/YYYY)_____/_____/_____

ASSIGNMENT OF BENEFITS AND AUTHORIZATIONS

I hereby authorize and direct my insurance company to make payments directly to the providers of WEST BROWARD PEDIATRICS, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this Assignment. This Authorization will remain in effect until rescinded by myself in writing. I further permit a copy of this Authorization be used in place of the original. This Authorization is to apply to all claims submitted by the providers of WEST BROWARD PEDIATRICS. I hereby authorize the providers to release any information required in the course of the examination or treatment.

To avoid misunderstandings regarding medical insurance, all patients should understand that all professional services rendered are charged directly to the patient and that all patients are personally responsible for payment of fees. As a courtesy, we will prepare all necessary forms to help you obtain benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees. If your insurance company does not cover the fees in full, the balance is due in full and payable by you.

A $10.00 Administrative Fee, due to processing services will be applied to all unpaid balances not paid by the due date on your monthly statement.

I authorize WEST BROWARD PEDIATRICS and it's agents Dr. Michael Morrison, Dr. Alicia Salland, Dr. Paole Paré, Brenda Austin, APRN, Amber Badal, APRN, and Kelly Stars, APRN to render any emergency care for my children if I cannot be located at the time of emergency.

PARENT/LEGAL GUARDIAN SIGNATURE (OR SIGNATURE OF PATIENT 18 YEARS OR OLDER):

_____ DATE:_____/_____/_____

PRINTED NAME:_____ STAFF INITIALS _____