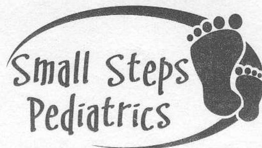
PATIENT INFORMATION FORM - PLEASE PRINT



DATE

OFFICE USE ONLY

REFERRED BY (PRIMARY CARE PHYSICIAN IF REQUIRED BY INS. CO.)	ADDRESS (STREET, CITY, ZIP CODE)	PHONE NO.

PATIENT INFORMATION

PATIENT'S LAST NAME	SUFFIX (JR, ETC.)	FIRST NAME	M.I.	NICKNAME

PATIENT'S STREET ADDRESS	ZIP CODE	CITY	STATE

SOC. SEC. NO.	HOME PHONE NO.	WORK PHONE NO.	CELL PHONE NO.	SEX		MARITAL STATUS				DATE OF BIRTH
				M	F	S	M	W	D	

FATHER RESPONSIBLE PARTY INFORMATION

RELATIONSHIP TO PATIENT	NAME OF RESPONSIBLE PARTY	SOC. SEC. NO.	DATE OF BIRTH

STREET ADDRESS (IF DIFFERENT THAN PATIENT)	ZIP CODE	CITY	STATE

HOME PHONE NO.	WORK PHONE NO.	CELL PHONE NO.	NAME OF EMPLOYER (WORK)

EMPLOYER'S STREET ADDRESS	ZIP CODE	CITY	STATE

MOTHER RESPONSIBLE PARTY INFORMATION

RELATIONSHIP TO PATIENT	NAME OF RESPONSIBLE PARTY	SOC. SEC. NO.	DATE OF BIRTH

STREET ADDRESS (IF DIFFERENT THAN PATIENT)	ZIP CODE	CITY	STATE

HOME PHONE NO.	WORK PHONE NO.	CELL PHONE NO.	NAME OF EMPLOYER (WORK)

EMPLOYER'S STREET ADDRESS	ZIP CODE	CITY	STATE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

NAME OF INS. CO.		
GROUP NO.	POLICY NO.	EFFECTIVE DATE
RELATIONSHIPTO PATIENT	NAME OF INSURED (AS IT APPEARS ONYOUR CARD)	
DATE OF BIRTH	INSURED'S EMPLOYER	COPAY

SECONDARY INSURANCE COMPANY

NAME OF INS. CO.		
GROUP NO.	POLICY NO.	EFFECTIVE DATE
RELATIONSHIPTO PATIENT	NAME OF INSURED (AS IT APPEARS ONYOUR CARD)	
DATE OF BIRTH	INSURED'S EMPLOYER	COPAY

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

PERSONTO CONTACT	RELATIONSHIP	PHONE NO.

STREET ADDRESS	CITY	STATE	ZIP

AUTHORIZATION AND RELEASE

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse, or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize Small Steps Pediatrics, P.C. to furnish any medical information requested by insurance companies with whom I have coverage or public agency which may be assisting in payment of the patient's care and/or any physician(s) referring patient for treatment.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to Small Steps Pediatrics, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Small Steps Pediatrics, P.C. charges for these services. I understand that I am financially responsible to Small Steps Pediatrics, P.C. for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Small Steps Pediatrics, P.C., I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

Guarantor's Signature: ______________________________ **Date:** ______________

REORDER FORM PI-1