

Patient Profile

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ [] Home [] Cell

Phone: _____ [] Home [] Cell

GUARANTOR

Name: _____

Address: _____

City, State: _____

PRIMARY INSURANCE

Same as Patient Same as Guarantor Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____

Member ID: _____

Policy Group: _____

Date of Birth: _____

HMO PPO POS

Drug Allergies: _____

Pharmacy Phone/Name: _____

Patient ID #: _____

Date of Birth: _____

Social Security #: _____

CONTACTS

I hereby give consent to Azle Pediatrics to release information concerning my medical condition and treatment to the following people. ***

EMPLOYMENT

Employer: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

SECONDARY INSURANCE

Same as Patient Same as Guarantor Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____

Member ID: _____

Policy Group: _____

Date of Birth: _____

HMO PPO POS

ASSIGNMENT & RELEASE

I hereby give lifetime authorization for payment of insurance benefits to be made to Azle Pediatrics and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I also understand it is my responsibility to remit payment for deductibles, co-pays, and charges not covered by my insurance plan. In order for this office to process my claim, it is important that I present my insurance card as each visit. If a problem occurs with my claim, coverage is terminated, or denied, it is my responsibility to insure payment, contact my insurance, or initiate a payment plan until the insurance problem is resolved. Past due accounts are subject to credit processing.

Date

 X
Signature of patient or guardian

Relationship to patient

I have reviewed the Notice of Privacy Practice, which explains how my medical information will be used & disclosed. I understand I may receive a printed copy of this information upon verbal or written request now or in the future.

 X
Signature of patient or guardian

Date