Patient Information

Azle Pediatrics

PATIENT NAME (First Name, Middle Initial, Last Name) PATIENT ID (Office Use Only)	FIRST PHONE (HOME)	SECOND PHONE (WORK)	THIRD PHONE (MOBILE)
ADDRESS DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER	OCCUPATION	PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS			
PRIMARY CARE DOCTOR NAME & ADDRESS			

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)			
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M or F)	PATIENT'S RELATION TO RES
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Authorization and Acknowledgement

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 fee. 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 at each visit. If a problem occurs with my claim, coverage is terminated, or denied, it is my responsibitlity 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

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