## 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) | FIRST PHONE (HOME) | SECOND PHONE (WORK) | THIRD PHONE (MOBILE) |
|---|---|---|---|
| ADDRESS | | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| CITY, STATE, ZIP | | SEX (M or F) [ ]M [ ]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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