Pediatric and Adolescent Medicine—Alexius M. Bishop, M.D., P.S.C.

PATIENT INFORMATION SHEET FOR PATIENTS > 18 Y/O

PATIENT'S FULL NAME	RACE/ETHNICITY	DATE OF BIRTH	SEX
______________________	____________	____________	____

HOME ADDRESS:______________________________ ______________, ______ ________

HOME PHONE:________________________________ CELL#: ________________________

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME______________________________
DOB______________________________
SOCIAL SECURITY #______________________________
ADDRESS______________________________
HOME PH.________________ CELL____________
EMPLOYER______________________________
WORK PHONE______________________________

MOTHER'S NAME______________________________
DOB______________________________
SOCIAL SECURITY #______________________________
ADDRESS______________________________
HOME PH.________________ CELL____________
EMPLOYER______________________________
WORK PHONE______________________________

PRIMARY INSURANCE

COMPANY______________________________
EFFECTIVE DATE______________________________
SUBSCRIBER NAME______________________________
SUBSCRIBER DATE OF BIRTH______________________
EMPLOYER______________________________
GROUP #______________________________
SUBSCRIBER #______________________________

SECONDARY INSURANCE

COMPANY______________________________
EFFECTIVE DATE______________________________
SUBSCRIBER NAME______________________________
SUBSCRIBER DATE OF BIRTH______________________
EMPLOYER______________________________
GROUP #______________________________
SUBSCRIBER #______________________________

PLEASE PRESENT CHILD'S INSURANCE CARD SO IT CAN BE COPIED

EMERGENCY CONTACT (NOT LIVING WITH YOU)
NAME______________________________ RELATIONSHIP______________________
ADDRESS__________________________ ________________ ________ __________
HOME #.____________________ CELL #____________________ WORK #____________________

RELEASE OF INFORMATION

I consent to the use and release of any information, including the diagnosis and the records of any treatment or examination rendered by the medical practice of Alexius M. Bishop, M.D., P.S.C. to the above individuals listed who have authority to act on behalf of the patient child (children), insurance companies, governmental payers, healthcare practitioners and other persons/entities for purposes of treatment, payment and business operation of the Alexius M. Bishop, M.D., P.S.C..

Please check one:

______Okay to release medical information to parents ______ Do Not release medical information to parents

Signature:______________________________ Date:______________________

FOR OFFICE USE: UPDATED BY:________________ DATE:______________ UPDATED: June 2011