

PATIENT INFORMATION SHEET

“To be completed by parent of guardian”

One form may be completed for all children IF the information listed below is same for all children.

PATIENT’S FULL NAME	DATE OF BIRTH	RACE/ETHNICITY	SEX
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOME ADDRESS: _____
HOME PHONE: _____ CELL # _____

RESPONSIBLE PARTY INFORMATION

FATHER’S NAME _____	MOTHER’S NAME _____
DOB _____	DOB _____
SOCIAL SECURITY # _____	SOCIAL SECURITY # _____
ADDRESS _____	ADDRESS _____
HOME PH. _____ CELL _____	HOME PH. _____ CELL _____
EMPLOYER _____	EMPLOYER _____
WORK PHONE _____	WORK PHONE _____
EMAIL ADDRESS _____	EMAIL ADDRESS _____

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..

I, the undersigned, authorize and request my insurance company or governmental payer to pay directly to any doctor of this medical practice insurance benefits otherwise payable to the undersigned.

FINANCIAL RESPONSIBILITY:

I, the undersigned, understand my insurance carrier may pay less than the actual bill for services. Regardless of insurance benefits, or the designation of some other responsible party above, I agree to be responsible for payment of all services rendered on my behalf or on behalf of my child (children) and/or dependents. If and when my child (children) and/or dependents are over the age of eighteen (18) years, I understand my financial responsibility for him/her/them will remain unless I have provided written notification to Alexius M. Bishop, M.D., P.S.C. that I will no longer be responsible prior to the rendering of services for said child (children) and/or dependent.

Signature of Parent/Legal Guardian/Responsible Party

Date

I have read/acknowledged receipt of: HIPPA Policy: Initial _____ Date: _____ Financial Policy: Initial _____ Date: _____