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

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______________________________
DOB______________________________
SOCIAL SECURITY #______________________________
ADDRESS______________________________
HOME PH.______________CELL______________
EMPLOYER______________________________
WORK PHONE______________________________
EMAIL ADDRESS______________________________

MOTHER'S NAME______________________________
DOB______________________________
SOCIAL SECURITY #______________________________
ADDRESS______________________________
HOME PH.______________ CELL______________
EMPLOYER______________________________
WORK PHONE______________________________
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.
My signature below acknowledges I have read and received a copy of the office HIPAA Policy and Financial Policy.

____ ______________________

Signature of Parent/Legal Guardian/Responsible Party **Date**

FOR OFFICE USE: UPDATED BY:____________________ DATE:______________ UPDATED: September 2017