PATIENT INFORMATION SHEET

To be completed by parent or guardian – DOB and SS# to be completed at office

PATIENT'S FULL NAME	D.O.B	RACE/ETH	SEX	Pref. Doctor
______________________________	__________	__________	____	Dr.______________
______________________________	__________	__________	____	Dr.______________
______________________________	__________	__________	____	Dr.______________
______________________________	__________	__________	____	Dr.______________
______________________________	__________	__________	____	Dr.______________

BILLING ADDRESS: ____

CITY______________________________ STATE___________________ ZIP_____________

PRIMARY CELL PHONE #______________________________ ALT. PHONE #__________________________

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME______________________________
DOB____________ SS#______________________
ADDRESS ______________________________
____
PREFERRED PHONE #______________________
EMPLOYER______________________________
WORK PHONE______________________________

MOTHER'S NAME______________________________
DOB____________SS# ______________________
ADDRESS ______________________________
____
PREFERRED PHONE #______________________
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__________________________ __CITY______________________STATE_________ ZIP____________
PREFERRED PHONE #.________________________ ALTERNATE PHONE #______________________________

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: 02/05/2020