PATIENT INFORMATION SHEET
"To be completed by parent or guardian"

PATIENT'S FULL NAME	D.O.B	RACE/ETH	SEX	Pref. Doctor
			M	Dr. Dr. Bishop
			M	Dr. Dr. Bishop
			M	Dr. Dr. Bishop
			M	Dr. Dr. Bishop
			M	Dr. Bishop

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 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: 05/25/2021