

FAMILY/PATIENT INFORMATION SHEET - 2010

MOTHER'S INFORMATION

Name: _____
Last
First
Middle Initial

Home Address: _____
Street
City
State
Zip Code

Home Phone #: (____) _____ Work Phone #: (____) _____

Cell Phone #: (____) _____

Date of Birth: Month _____ Day _____ Year _____ Social Security # _____

Marital Status (circle one): Married Divorced Separated Widowed Single

Employer: _____ Occupation: _____

How did you hear about us? _____

Email Address: _____

FATHER'S INFORMATION

Name: _____
Last
First
Middle Initial

Home Address: _____
Street
City
State
Zip Code

Home Phone #: (____) _____ Work Phone #: (____) _____

Cell Phone #: (____) _____

Date of Birth: Month _____ Day _____ Year _____ Social Security # _____

Marital Status (circle one): Married Divorced Separated Widowed Single

Employer: _____ Occupation: _____

Email Address: _____

Child: _____
First Name
Middle Initial
Last Name
Birthdate

Child: _____
First Name
Middle Initial
Last Name
Birthdate

Child: _____
First Name
Middle Initial
Last Name
Birthdate

Child: _____
First Name
Middle Initial
Last Name
Birthdate

Child: _____
First Name
Middle Initial
Last Name
Birthdate

PLEASE COMPLETE BACK OF FORM →

PATIENT EMERGENCY CONTACT (NOT LIVING WITH PATIENT)

Name: _____ Phone Number: () _____

Address: _____ City: _____

State: _____ Zip Code: _____ Work Phone Number: _____

Relationship to Patient: _____

FINANCIAL ARRANGEMENTS AND INSURANCE

Co-payments are due at the time services are rendered. We accept cash, check, MasterCard, Visa and Discover.

If you have medical insurance, Arlington Pediatrics, Ltd. will submit claims directly to your insurance company. Your insurance is a contract between you, your employer and the insurance company. Arlington Pediatrics, Ltd. is not a party to that contract. Not all services are a covered benefit in all contracts, and it is your responsibility to be aware of what benefits your insurance entitles you to. We will assist you to receive your maximum allowable benefits.

We emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your patient due balance. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account.

By signing below, I agree and understand all of the above statements regarding financial arrangements and insurance. I authorize payment of medical benefits directly to Arlington Pediatrics, Ltd.

Signature of Parent/Guardian

Date

AUTHORIZATION TO TREAT

We recognize there may be occasions when neither parent (or guardian) is available to bring their child(ren) to our office. Your signature below will allow us to provide care for your child(ren) in your absence. Otherwise we will need to obtain your written permission prior to caring for your child(ren) for each occasion of your absence.

I authorize the doctors of Arlington Pediatrics, Ltd. to provide medical care and treatment for my child(ren) in my absence, including but not limited to routine examinations, immunizations and lab tests.

Signature of Parent/Guardian

Date