DOCTORS FOR KIDS
PATIENT INFORMATION SHEET

Patient Name:_____ Today's date:_____
Sex: Male Female DOB_____ Social Security Number_____
Mothers Name:_____
Fathers Name:_____
Person financially responsible for this account_____
Home address:_____City_____State____Zip_____
Home Phone#_____ Mother's cell _____Father's cell_____
Email Address:_____
Emergency Contact_____ Relation_____Phone_____
Pharmacy_____ Pharmacy Number:_____
Whom May we thank for referring you?_____

INSURANCE INFORMATION

Primary Insurance_____ Ins Phone# _____
Insurance address:_____
Contract Number_____Group Number_____
Subscribers Name:_____ Subscribers DOB_____
Relationship to Patient:_____

Secondary Insurance_____ Ins Phone# _____
Insurance address:_____
Contract Number_____ Group Number_____
Subscribers Name:_____ Subscribers DOB_____
Relationship to Patient_____

AUTHORIZATION FOR TREATMENT

I authorize Doctors for Kids to provide medical treatment for my child:
Patients name:_____
Signature_____ Relation to patient _____

ASSIGNMENT AND RELEASE

I undersigned certify that I (or my dependent) have treatment for my child
Patients Name_____

And assign to Dr. Mavani all insurance benefits, in any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all submissions.

_____ _____ _____
Responsible Party Signature Relationship Date