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