

SCHWARTZ PEDIATRICS

PATIENT INFORMATION

*PATIENT _____
First Middle Last Birthdate Age Sex

HOME ADDRESS _____ HOME PHONE () _____
Street City State Zip

*FATHER _____
First Middle Last Birthdate Age

SOCIAL SECURITY # _____ DRIVER'S LICENSE# _____ CELL PHONE () _____

FATHER EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE () _____
Street City Zip

*MOTHER _____
First Middle Maiden Last Birthdate Age

SOCIAL SECURITY # _____ DRIVER'S LICENSE# _____ CELL PHONE () _____

MOTHER EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE () _____
Street City Zip

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY _____

ADDRESS _____ PHONE () _____
Street City State Zip

INSURED'S NAME _____ POLICY # _____ GROUP/PLAN# _____

INSURED'S SOCIAL SECURITY # _____ INSURED'S BIRTHDATE _____

SECONDARY INSURANCE

INSURANCE COMPANY _____

ADDRESS _____ PHONE () _____
Street City State Zip

INSURED'S NAME _____ POLICY# _____ GROUP/PLAN# _____

INSURED'S SOCIAL SECURITY # _____ INSURED'S BIRTHDATE _____

*NEAREST RELATIVE NOT LIVING WITH YOU _____
Full Name Address Phone

REFERRED BY _____
Full Name Address Phone

LIST ALL OTHER MEMBERS OF PATIENT'S IMMEDIATE FAMILY _____

I acknowledge full responsibility for payment of such services and agree to pay them in full, AT THE TIME OF SERVICE, unless other arrangements are made in advance. In addition, I hereby assign to the doctor whose practice name appears above, all money to which I am entitled for medical expenses relative to the services performed. I understand I am financially responsible to said doctor for the charges not covered by this assignment.

SIGNATURE _____ DATE _____
(Parent, if minor)