

MAPLE AVENUE PEDIATRICS - NEW PATIENT INFORMATION FORM

BILLING INFORMATION

Form with fields: FAMILY NAME, DATE, REFERRED BY, FILE #, NAME OF PARENT/GUARDIAN RESPONSIBLE FOR BILL, STREET ADDRESS, CITY, STATE, ZIP CODE, HOME PHONE, CELL PHONE, DATE OF BIRTH, SEX-M, F, RELATIONSHIP TO PATIENT, MARITAL STATUS, PREVIOUS M.D., SOC. SECURITY NUMBER, OCCUPATION, NAME OF EMPLOYER, BUSINESS PHONE, EMPLOYER ADDRESS, CITY, STATE, ZIP CODE, IN CASE OF EMERGENCY, CONTACT: PHONE, STREET ADDRESS, CITY, STATE, ZIP CODE

SPOUSAL INFORMATION

Form with fields: SPOUSES NAME, DATE OF BIRTH, SEX-M, F, STREET ADDRESS, CITY, STATE, ZIP CODE, HOME PHONE, BUSINESS PHONE, CELLPHONE, SOC. NUMBER, OCCUPATION, RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

Form with fields: NAME OF INSURANCE COMPANY TO BILL, LABORATORY, STREET ADDRESS, CITY, STATE, ZIP CODE, ID NUMBER, EFFECTIVE DATE, COPAY, TYPE OF COVERAGE, LOCAL GROUP NUMBER, NAME OF POLICY HOLDER, DATE OF BIRTH OF POLICY HOLDER

PATIENT INFORMATION

Form with fields: LAST NAME, FIRST NAME, BIRTHDATE, SEX- M, F (repeated 4 times)

SIGNATURE ON FILE: I hereby authorize release of information to my insurance company and assign benefits otherwise payable to me, to the doctor indicated on the claim. I understand that I am financially responsible for all charges, including collection fees. NOTE: It is our policy to file insurance ONLY when we are a participating provider in a specific insurance plan, however we need a signature on file for all patients. We do not submit to secondary insurance companies.

SIGNATURE DATE

NAME RELATIONSHIP