Pediatric Associates of Julington Creek

Patient Information

Office Use Only

Today's Date: _____Referred By: _____

PATIENT INFORMATION:

(Please Print)

Full Legal name: _____ Preferred Name: _____

Race:↑Caucasian (white)↑American Indian↑ African American (black)↑Hispanic↑ Biracial Asian Oriental↑Other↑Unknown

Date of Birth: _____ SS# _____-_____-_____ Sex: Male Female

Home Address: _____City: _____State: _____

Zip Code: _____ County: _____

Mail to Address: _____City: _____State: _____
(If different)

Zip Code: _____ County: _____

Primary Phone Number: (_____) _____-_____

Secondary Phone Number: (_____) _____-_____

Preferred Language: _____ E-mail: _____

Name of School/Daycare: _____

PARENT / GUARDIAN INFORMATION:

Father: _____DOB: _____SS# _____-_____-_____

Employer: _____

Work # (_____) _____-_____ Cell # (_____) _____-_____

Address: _____City: _____State: _____
(If different)

Zip Code: _____ County: _____

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Mother: _____DOB: _____SS# _____-_____-_____

Employer: _____

Work # (_____) _____-_____ Cell # (_____) _____-_____

Address: _____City: _____State: _____
(If different)

Zip Code: _____ County: _____

Emergency Contact:

Name: _____ Relationship_____
(Other than PARENT)

Address: _____City: _____ State: _____

Zip Code: _____

Phone #: (_____) _____-_____ Cell #: (_____) _____-_____

GUARANTOR INFORMATION:

Name: _____ Patient Relation to Guarantor: _____

DOB: _____ SS# _____-_____-_____ Primary Phone: (_____) _____-_____

Address: _____City: _____State: _____

Zip Code: _____

Insurance Company Name:_____

Phone Number: (_____) _____-_____

Identification Number: _____ Group Number: _____

Effective Date: _____

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ASSIGNMENTS OF INSURANCE BENEFITS

I herby authorize direct payment of surgical/ medical benefits to Dr. Garcia/Luz for services rendered by him /her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance company. I also understand that I will be charged 10% of my balance every 90 days, after a statement has been sent, that the balance has not been paid.

AUTHORIZATION TO RELEASE INFORMATION

I herby authorize Dr. Garcia/Luz to release ant medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of records on request. I request that the payment of authorize benefits be made on my behalf.

PARENT/GAURDIAN _____

(Please print)

SIGNATURE: _____ DATE: _____