The Pediatric Center

Patient Information Sheet

Date: ______________________________

Patient's Name ____ Date of Birth: ________________SSN:______________________

Mailing Address: ____, _____________________, _________________, ____________
PO Box or Street City State Zip

Home Phone: ________________________________Work Phone: ________________________Cell Phone: _____________________

Mother's Name: ____Date of Birth: ________________SSN:______________________

Mailing Address: ____, _____________________, _________________, ____________
PO Box or Street City State Zip

Father's Name: ____Date of Birth: ________________SSN:______________________

Mailing Address: ____, _____________________, _________________, ____________
PO Box or Street City State Zip

Person Responsible for Medical Expenses: ______________________________________Relationship:_________________________

Primary Insurance information
Insurance Company: ____Subscriber ID: ____________________
Subscriber Name:____ Subscriber Date of Birth:__________________
Subscriber Mailing Address: ____
Subscriber Social Security Number: ____

Secondary Insurance information
Insurance Company: ____Subscriber ID: ____________________
Subscriber Name: ____ Subscriber Date of Birth: _________________
Subscriber Mailing Address: ____
Subscriber Social Security Number: ____

1. I certify to the best of my knowledge the above information is correct.
2. I authorize The Pediatric Center to review my insurance coverage with my insurance company as indicated.
3. I authorize The Pediatric Center to release medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered.
4. I further authorize the release to The Pediatric Center of such information as may be necessary for the purpose by my insurance company.
5. I permit a copy of this authorization to be used in place of the original.
6. I hereby authorize you to pay directly to The Pediatric Center benefits due me out of my indemnity under the terms of my insurance company policy.
7. The undersigned agrees that all services are rendered on a paid basis only. If payments are not received within 60 days of visit, collection may become necessary. The undersigned shall pay all costs including attorney's fees.
8. I authorize The Pediatric Center to release copies of my medical records to other medical providers to whom I may be referred to further patient care.
9. I understand that The Pediatric Center encourages patients to receive all required immunizations as recommended by the American Academy of Pediatrics and the State of Louisiana Dept of Health.
10. I understand that The Pediatric Center complies with all HIPAA regulations and that a copy of the complete HIPAA policy is available for review upon request.

____ ________________
Signature of Parent/Guardian *Date*