Hilliard Pediatrics ***All information must be filled out.***

Patient Information

Patient_____

Last First MI Prefer to be called

DOB_____ SS#_____ Gender M____F_____ Primary Dr_____

Mailing Address_____ City_____ ST_____ Zip_____

Home Phone_( )_____ Siblings First and Last Names_____

Mother/ Legal Guardian's Information Who referred you to our office?

Mothers Name_____ DOB_____ SS#_____

Mother's Address _____ City_____ ST_____ ZIP_____

Home Phone( )_____ Cell# ( )_____ Drivers Lic#_____

Employer_____Position_____Work Phone ( ) _____

Address _____ City _____ST_____ Zip_____

Father's Information

Father's Name_____- DOB_____ SS#_____

Father's Address_____ City_____ ST_____ Zip_____

Home Phone ( ) _____ Cell# ( ) _____ Driver's Lic#_____

Employer _____ Position_____ Work Phone ( ) _____

Address_____ City_____ST_____ Zip_____

Emergency Contact Person _____ Relationship_____ Phone #_____

Person Responsible for Account Payment

Name_____

If Responsible party other than Parent above Please Provide the Following Information.

Relation to Patient_____SS#_____ DOB_____

Address_____City_____ST_____ Zip_____

Home Phone ( ) _____ Work# ( ) _____ Cell # ( ) _____

Insurance Information

Plan Name	Policy Holder	Policy #	Effective date	exp date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is there a court order prevention either parent from access to the patient's medical information? Yes_____ NO____ If yes, please provide us with a copy of the legal document.

I verify the above information is accurate and authorize release of medical information necessary to process claim.

_____ Date_____

I request payments of this claim and if the payer accepts assignment, I authorize payment directly to the physician.

_____ Date_____