

Chart #: _____

FAMILY INFORMATION 2008

Date: _____

(PLEASE COMPLETE BOTH SIDES)

PATIENT(S) NAME	SEX	DOB	SOCIAL SECURITY #	Medicaid #(if applicable)
Home Address: _____		Phone # () _____		
City _____	State _____	Zip _____		
E-mail address: _____				
Primary Care Provider (Physician) _____				

Father's Name: _____	Date of Birth _____	Social Security # _____
Father's Address: _____	Phone # () _____	
Father's Employer: _____	Phone # () _____	
Employer's Address: _____		

Mother's Name: _____	Date of Birth _____	Social Security # _____
Mother's Address: _____	Phone # () _____	
Mother's Employer: _____	Phone # () _____	
Employer's Address: _____		

Primary Health Insurance Co.: _____	Phone # () _____
Policy ID# _____	Group # _____
Policy Holder _____	Relationship to patient _____

Secondary Health Insurance Co.: _____	Phone# () _____
Policy ID# _____	Group # _____
Policy Holder _____	Relationship to patient _____

In Case of Emergency Contact (other than parent) _____
Relationship to Patient _____ Phone# () _____
Patient Referred By _____

AUTHORIZATION TO SEEK MEDICAL TREATMENT

The following individuals are hereby authorized to seek medical treatment for my child(ren) in my absence:
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Signature of Parent/Guardian: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGN BENEFITS

I hereby authorize the release of any medical information to process an insurance claim and in the case of assigned benefits, do hereby authorize payment directly to the physician.
Signature of Parent/Guardian _____ Date: _____

ASSUMPTION OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible to the doctor for all charges incurred on my account whether covered by my insurance company or not. These charges are to be paid at the time services are rendered unless submitted to an insurance company with whom Pediatric and Adolescent Center of Grand Prairie & Arlington (Dr. Epifania Caturay, et al) has a participating contract. I also understand that non-covered services under my insurance policy and outstanding balances become my full responsibility. In the event collections proceedings are instituted to enforce payment of fees due to Pediatric and Adolescent Center of Grand Prairie & Arlington (Dr. Epifania Caturay, et al), I/we, the undersigned agree to pay the additional sum of twenty-five percent (25%) of the principal due as attorney fees, plus all associated court fees.
Signature of Parent/Guardian: _____ Date: _____

**IT IS YOUR RESPONSIBILITY TO NOTIFY
THIS OFFICE IMMEDIATELY OF ANY
CHANGES TO THE ABOVE INFORMATION**

I HAVE REVIEWED THE 2007 INFORMATION.
MY FAMILY'S PERSONAL AND INSURANCE
INFORMATION HAS NOT CHANGED.
Name _____ Date _____
Relationship to Patient: _____