

2012

CHILDREN'S MEDICAL GROUP, P.C.

2012

LIST ALL CHILDREN SEEN BY OUR OFFICE

CHILD'S NAME _____ DOB ____/____/____ SEX _____
LAST FIRST MIDDLE

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LAST FIRST MIDDLE

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LAST FIRST MIDDLE

CHILD'S NAME _____ DOB ____/____/____ SEX _____
LAST FIRST MIDDLE

IF ALL REQUESTED INFORMATION BELOW DOES NOT APPLY TO ALL CHILDREN LISTED ABOVE, PLEASE REQUEST A SEPARATE INFORMATION SHEET.

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ CELL PHONE _____

ALTERNATE PHONE _____

AT WHICH NUMBER MAY WE LEAVE A CONFIDENTIAL MESSAGE?
HOME ____ CELL ____ ALTERNATE ____

EMAIL ADDRESS _____

PARENT NAME _____ DOB ____/____/____ SEX _____

PARENT NAME _____ DOB ____/____/____ SEX _____

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE COMPANY) _____

BILLING ADDRESS _____
(IF DIFFERENT THAN ABOVE) STREET CITY STATE ZIP

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

PRIMARY PROVIDER YOUR CHILD SEES AT CHILDREN'S MEDICAL GROUP _____

ETHNICITY: HISPANIC OR LATIN ____ NOT HISPANIC OR LATIN ____

PREFERRED PHARMACY _____ PHONE _____

STREET/CITY _____

THE INFORMATION ON THIS SHEET IS TRUE AND CORRECT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicaid, private insurance, or other health plans, to this practice. I understand it is my responsibility to pay any copayment, deductible, or co-insurance amount and that I am financially responsible for all charges whether or not paid by said insurance.

Children's Medical Group, P.C.'s Notice of Privacy Practices is available at www.cmg-pc.com. A hard copy will be provided upon my request.

SIGNATURE:

DATE: