

## PATIENT INFORMATION PROFILE

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's Primary Physician At This Office \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
First Middle Last

Cell # \_\_\_\_\_

Address \_\_\_\_\_ Home # \_\_\_\_\_  
Street Address Apt. No.

\_\_\_\_\_ City County State Zip

Father's Name \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Employed By \_\_\_\_\_ Business # \_\_\_\_\_

Mother's Name \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Employed By \_\_\_\_\_ Business # \_\_\_\_\_

Emergency Contact (not living with you) \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Business # \_\_\_\_\_

Parent who is financially responsible for child's account balance \_\_\_\_\_

Do you have insurance?  Yes  No *If yes, please provide us with a copy of your card.*

Do you have medicaid?  Yes  No *If yes, please provide us with a copy of your child's card.*

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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION** - I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

**ASSIGNMENT OF BENEFITS** - I hereby authorize payment directly to this practice of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment.

**GUARANTEE OF ACCOUNT** - I understand that I am financially responsible for all charges for service rendered to my child/children, including the balance remaining after payment of possible insurance benefits.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*