PATIENT INFORMATION

Patient's Name:

Date of Birth: Age: Patient Social Security #:

Address:

City,State & Zip Code:

Home Phone #: Cell phone #:

School: Grade: School District:

Mother's Name: Employer: Phone:

Father's Name: Employer Phone:

Patient lives with:

Referring Physician: Child's Primary Doctor:

LEGAL GUARDIAN INFORMATION (IF NOT PARENT)

Name: Relationship to Patient:

Address:

Phone #:

Emergency Contact:

INSURANCE INFORMATION

Insurance Co.: Phone #:

Insurance Address:

Group #: Certificate or ID #:

Policy Holder's Name: Relationship to Patient: Self / Spouse / Dependent/ Parent

Policy Holder's Employer: Phone #:

Employer's Address:

Policy Holder's Social Security #: Date of Birth: Sex: Male /Female

I hereby assign, transfer, and set over to Andrew H. Martin, M.D. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature or Guardian Date