

UPDATED IN COMPUTER: _____

UPDATED IN CHART: _____

Acct. # _____

SUMMERWOOD PEDIATRICS

Father's Name _____ SS# _____ DOB _____
Home Address _____ City _____ Zip _____
Home Phone # _____ Work Phone # _____
Employer Name and Address _____

Mother's Name _____ SS# _____ DOB _____
Home Address (if different from above) _____ City _____ Zip _____
Home Phone # _____ Work Phone # _____
Employer Name and Address _____

	Child #1	Child #2	Child #3	Child #4	Child #5
Last Name					
First Name					
Middle Name					
Date of Birth					
Sex					
SS#					
With Whom Child Resides					

Nearest Relative/Contact not Living with Patient

Name _____ Relationship _____
Address _____ Phone # _____

BILLING/INSURANCE INFORMATION

Primary Insurance Co. _____ Effective Date _____
Responsible Party/Subscriber _____
ID# _____ Group # _____

Secondary Insurance Co. _____ Effective Date _____
Responsible Party/Subscriber _____
ID# _____ Group # _____

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private Insurance Companies, and any other health plan to be paid directly to Summerwood Pediatrics. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid or allowed by the insurance companies. I hereby authorize said assignee to release all information necessary to secure payment. In the event my account is assigned for collection, I agree to pay an additional 30% collection fee based on the total amount overdue, as well as, any associated attorney fees.

Signature _____ Date _____