DAILEY PEDIATRICS + family medicine

NEW PATIENT INFORMATION

Date:_____

Patients Legal Name:_____

Date of Birth:_____ Male/Female (Please Circle)

Marital Status:_____ Ethnicity:_____

Street Address:_____

City/State/Zip code :_____

Home phone:_____Cell phone:_____

Patient's Employer/Parent employer:_____

Occupation:_____

Employer Address:_____

Work Phone:_____

Spouse Name(if applicable):_____

Spouse SSN#:_____

Spouse Date of Birth:_____

Pediatric Patient only(please list both parents if applicable)*

Parent Name/Legal Guardian:_____

Parent(Mother) SSN#:_____

Parent(Mother) Date of Birth:_____

Parent (Father) SSN#:_____

Parent (Father) DOB#:_____

Parent(Mother) Cell:_____

Parent(Father) Cell:_____

Parent Employer:_____

Parent Occupation:_____

Business Phone:_____Business email:_____

Employer Street Address:_____

City/State/Zip:_____

Parent Employer:_____

Parent Occupation:_____

Business Phone:_____Business email:_____

Employer Street Address:_____

City/State/Zip:_____

Emergency #1 Contact Name:_____

Emergency Contact Number:_____

Emergency #2 Contact Name:_____

Emergency Contact Number:_____

Were you referred by someone to us? If so who:_____

Person Responsible for Payment:_____

Street Address:_____

City/State/Zip code:_____

Home phone:_____

Primary Insurance:_____

Policy Holder name/SSN/DOB:_____

_____

Policy Number/Member ID #_____

Group #:_____

Secondary Insurance:_____

Policy holder name/SSN/DOB:_____

_____

Policy Number/Member ID#:_____

Group #:_____

Please Read: All charges are due at the time of service. The patient is responsible for all feed regardless of insurance. It is our policy that progressional services provided in our office be paid at the time of service. There will be a $25 late fee per month on accounts that are 60 days past due. We are in the process of credentialing with multiple private insurance companies and Medicare. As of now, we are a cash only practice. Once we get contracts back and signed with insurance companies, we will begin to file claims with your insurance. You may provide a receipt of services yourself to your insurance company in order for the services to go towards any deductible you may have and for any reimbursement insurance may provide you. If you would like a receipt to submit to your insurance, please let the receptionist or nurse aware prior to leaving the office.

As we obtain contracts with insurance companies, we will let you know at your time of visit.

I hereby authorize Dailey Pediatrics and Family Medicine, P.C. to collect payment at time of service in the form of cash, check, credit or debit. I understand that this is a cash only office at this time, however that can change once insurance contracts are put into pace. At this time, I will be made aware at my office visit and give permission for Dailey Pediatrics and Family Medicine to furnish information to insurance carriers concerning my illness and treatments, and i hereby assign to Dailey Pediatrics and Family Medicine all payments for medical services rendered to myself and dependants. I understand I am responsible for any amount not covered by Insurance.

_____ _____

Signature **Date**