Patient Information / Update

To avoid mistakes and delays in filing your insurance claim, all questions must be answered completely and legibly.

Patient Information

Patient's Full Name: _____
First Middle Last

Patient's Address: _____
Street Address Apartment Number

City:_____ State: _____ Zip Code:_____

Phone Number: _____
Home Cellular

Patient's Date of Birth: _____/_____/_____ Male ____ Female _____

Patient's Social Security Number _____-_____-_____

Guardian Information

Mother's Full Name:_____
First Middle Last

Address:_____
Street Address Apartment Number

City:_____ State:_____ Zip Code:_____

Phone Number: _____ Date of Birth: _____

Mother's SS Number: _____-_____-_____ Driver's License No.:_____

Mother's Place of Employment/Occupation:_____

Workplace Phone Number:_____ Ext: _____

Father's Full Name:_____
First Middle Last

Address:_____
Street Address Apartment Number

City:_____ State: _____ Zip Code: _____

Phone Number:_____ Date of Birth: _____

Father's SS Number: _____-____-_____ Driver's License No.:_____

Father's Place of Employment/Occupation:_____

Workplace Phone Number:_____ Ext:_____

Emergency Information

Name of person to be contacted in case of an emergency (other than those listed above):

Name: _____ Relationship:_____

Address:_____

Phone Number: _____
Home/Work Cellular

Insurance Information

Insurance will not be filed on your behalf without complete information. To avoid getting an unnecessary bill, please fill ALL blanks.

Insurance Carrier/Plan: _____Phone:_____

Claims Address:_____

Policy Holder's Name:_____ Date of Birth:_____/____/_____

Is this plan provided by your employer? Y/N____ Type of plan: HMO PPO Other_____
Circle One

Group Number:_____ Insurance ID No:_____

Effective Date of Coverage:_____ Place of Employement:_____

Amount of Deductible: $_____ Amount of Co-payment: $_____

Are well child care examinations and immunizations covered benefits in your policy? Y N
Circle one

Medical and Financial Policy

I authorize Tree House Pediatrics to render all necessary medical care to my child.

I understand that payment for non-covered services, co-payments, deductibles, etc. are due at the time of each visit. I authorize payment for medical services to be assigned to the physician at Tree House Pediatrics. I authorize Tree House Pediatrics to release all necessary medical information on my child to my insurance company.

I understand that I, the guardian, am ultimately responsible for all charges incurred for all services rendered, regardless of insurance.

Guardian Signature: _____ Date: _____