SLEEPING BEAR PEDIATRICS, P.C.

STEVEN A.J. ROSS, MD, FAAP

☐ New ☐ Update *PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED.* ***Present Insurance CARD****!!!!!!!!*

Date _____ / _____ / _____

CHILD INFORMATION

Last Name **First Name** **M. I** **Nickname**

_____ _____ _____ _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ - _____ **Date of Birth** _____ / _____ / _____CELL PHONE TO CALL 1st _____

Sex: (circle one) Male Female **Allergy to Medications**? _____

Please check the Ethnic Group(s) that apply:

❑ Caucasian ❑ Hispanic/Latino ❑ African American ❑ Asian ❑ Native American ❑ Alaskan Native ❑ Pacific Islander ❑Other _____

Preferred Language: (circle one) English Spanish Other: _____ RACE _____

PARENT OR GUARDIAN INFORMATION

*********<u>***WE CAN DISCUSS THE ACCOUNT ONLY WITH THE PATIENT AND THOSE LISTED BELOW FOR MINORS***</u>*********

Parent #1/Guardian Full Name _____

Relationship to Patient_____

Mailing Address_____

City _____ State _____ Zip _____

Phone (H) ( ) _____-_____

(W) ( ) _____-_____ Ext. _____

(C) ( ) _____-_____

Date of Birth _____/_____/_____

Employer_____

E-Mail _____

Parent #2/Guardian Full Name _____

Relationship to Patient_____

Mailing Address_____

City _____ State _____ Zip _____

Phone (H) ( ) _____-_____

(W) ( ) _____-_____ Ext. _____

(C) ( ) _____-_____

Date of Birth _____/_____/_____

Employer _____

E-Mail _____

EMERGENCY CONTACT

Give the name of nearest relative or of a close friend not living with you, to contact in case of an emergency.

Name_____ Home Phone_____ Work Phone _____

Relationship _____ City _____ State _____

INSURANCE INFORMATION

In order to avoid error or delay in the processing of your insurance claim, <u>***it is essential that the following section be fully and accurately completed.***</u>

Does the Patient have health insurance? (circle one) **Yes** **No**

Medicaid State ID # _____ *If the Patient's services are covered by Medicaid, please show your ID card to the receptionist.*

PATIENT'S HEALTH INSURANCE

Insurance Company _____

Policy Holder _____

First Name M.I. Last Name

Date of Birth_____ Relation to Patient_____

Policy Holder's cell phone number : _____

Group No_ _____ ID No._____

Employer_____ Effective Date_____

PATIENT'S SECONDARY INSURANCE

Insurance Company_____

Policy Holder_____

First Name M.I. Last Name

Date of Birth_____ Relation to Patient_____

Policy Holder's cell phone number : _____

Group No _____ ID No._____

Employer_____ Effective Date_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits to SLEEPING BEAR PEDIATRICS, PC, for these services and all future claims.
I authorize the release of any medical information necessary to process this claim and all future claims.

XXXXXX _____

(Signed Insured or Authorized Person)

SLEEPING BEAR PEDIATRICS, P.C.

STEVEN A.J. ROSS, MD, FAAP

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED. (PRINT)

ADDITIONAL FAMILY MEMBER PATIENT INFORMATION

To be completed for dependents with same guarantor as original patient only.

Please attach to *original* completed Patient Information form.

Last Name	First Name	M. I.	Gender	Date of Birth
______________	______________	______	________	____ / ____ / ____

Insurance Co	ID #	Nickname
______________	______________	______________

Last Name	First Name	M. I.	Gender	Date of Birth
______________	______________	______	________	____ / ____ / ____

Insurance Co	ID #	Nickname
______________	______________	______________

Last Name	First Name	M. I.	Gender	Date of Birth
______________	______________	______	________	____ / ____ / ____

Insurance Co	ID #	Nickname
______________	______________	______________

Last Name	First Name	M. I.	Gender	Date of Birth
______________	______________	______	________	____ / ____ / ____

Insurance Co	ID #	Nickname
______________	______________	______________

Last Name	First Name	M. I.	Gender	Date of Birth
______________	______________	______	________	____ / ____ / ____

Insurance Co	ID #	Nickname
______________	______________	______________

I authorize payment of medical benefits to SLEEPING BEAR PEDIATRICS, PC, for these services and all future claims.

I authorize the release of any medical information necessary to process these and all future claims.

X ________________________________

(Signed (Insured or Authorized Person)