

PATIENT INFORMATION SHEET (CHILD)

PATIENT NAME: LAST		FIRST	MIDDLE INITIAL	DATE OF BIRTH:
HOME ADDRESS:				
CITY:		STATE:	ZIP CODE:	
HOME PHONE:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F		
FATHER'S NAME:		SOC. SEC. NO:	DATE OF BIRTH:	
EMPLOYER:	YEARS EMPLOYED:	OCCUPATION:	BUS. PHONE:	
MOTHERS'S NAME:		SOC. SEC. NO:	DATE OF BIRTH:	
EMPLOYER:	YEARS EMPLOYED:	OCCUPATION:	BUS. PHONE:	
CHILDREN LIVING AT HOME: (names & birth dates)				
NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY:			PHONE:	

INSURANCE

PRIMARY INSURANCE CARRIER NAME:		POLICY ID #:	GROUP #:
INSURED'S NAME: LAST		FIRST	MIDDLE INITIAL
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
SOCIAL SECURITY # OF INSURED:		EMPLOYER PHONE:	
SECONDARY INSURANCE CARRIER NAME:		POLICY ID#:	GROUP#:
INSURED'S NAME: LAST		FIRST	MIDDLE INITIAL
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
SOCIAL SECURITY # OF INSURED:		EMPLOYER PHONE:	

PATIENT ELIGIBILITY WAIVER

I HEREBY ATTEST THAT I AM AN ELIGIBLE MEMBER OF THE HEALTH PLAN NOTED ABOVE. I AGREE THAT SHOULD IT BE DETERMINED THAT I AM INELIGIBLE FOR SERVICES RENDERED BY NEWPORT FAMILY MEDICINE OR BY ANOTHER FACILITY OR PHYSICIAN AS THE RESULT OF A NEWPORT FAMILY MEDICINE PRIMARY CARE DIRECT REFERRAL, I WILL BE RESPONSIBLE FOR PAYMENT TO NEWPORT FAMILY MEDICINE OR ITS AGENT FOR THOSE SERVICES DEEMED INELIGIBLE OR NOT COVERED.
 I AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN.
 I AUTHORIZE THIS PRACTICE TO ACT AS MY AGENT TO HELP ME TO SECURE PAYMENT FROM MY INSURANCE COMPANIES.

TO WHOM IT MAY CONCERN

I give my permission for the physicians at Newport Family Medicine to provide any necessary medical care to my minor child whose name is

_____ This authorization expires upon the minor's 18 birthday.

Signature

Print Name

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

In order to control costs of billing we request charges for office visits and/or co-payments be paid at the conclusion of each visit.

Signed: _____ Date: _____