



PATIENT INFORMATION (PLEASE PRINT & Fill Out Completely)

Date: _____

Patient's Name: First _____ Middle _____ Last _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Sex: qM qF

Patient's Street Address: _____

City, State, Zip Code: _____

Preferred Provider (please circle one): Dr. Hoos Dr. Mundy Preferred Pharmacy: _____

Parent or Person Responsible for Bill (person under which insurance is carried):

Relationship to Patient: _____ Date of Birth: _____ EMAIL: _____

Address: _____ Home Phone: (____) _____

City: _____ State: _____ Zip: _____ Mobile Phone: (____) _____

Marital Status of Parents: Married Divorced Separated Other: _____

IF NOT MARRIED, Who Has Custodial Rights: Mother ONLY Father ONLY Both Parents Other _____?

Father's Name: _____ DOB: _____ SS # _____ Cell

Phone: (____) _____ Work Phone: (____) _____

Father's Address: _____

Name of Employer: _____

Mother's Name: _____ DOB: _____ SS# _____ Cell

Phone: (____) _____ Work Phone: (____) _____

Mother's Address: _____

Name of Employer: _____

Emergency Contact not living with you:

Name & Relationship: _____ Phone: (____) _____

INSURANCE INFORMATION

Name of Insured:

Name of Insurance Company: _____ Phone: (____) _____

I.D. Number: _____ Group Number: _____

I certify that I will be financially responsible for all medical expenses for the above patient in the event they should lose coverage of Medicaid during the course of treatment. Sign _____

PLEASE READ: Payment is required *in full* at the time of each visit. The patient, their parent, or their guardian are responsible for all fees, regardless of Insurance coverage. We will file insurance only as a courtesy, but ultimately our patients are responsible for all outstanding balances regardless of coverage.

AUTHORIZATION:

I understand that I will be charged (not my insurance) for canceled appointments unless I give 24 hours' notice.

All of the office policies have been provided to me and I understand all policies. I agree to all policies that have been provided to me in writing.

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process insurance claims.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize and request payment of medical benefits directly to Premier Pediatrics of Muskogee.

I CERTIFY THAT I AM THE RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE

TO and SIGN ON BEHALF OF THE PATIENT FOR ALL SERVICES RENDERED. I, ALSO, CERTIFY THAT I AM THE FINACIALLY RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE and THAT I HAVE THE AUTHORITY TO AGREE TO ALL PRACTICE POLICIES AND FINANCIAL POLICIES.

Printed Name _____ Relationship _____

Signature _____ Date _____