

PARENT/GUARDIAN INFORMATION										
GUARDIAN'S NAME:LAST			FIRST		MI	ADDRESS			APARTMENT #	
CITY			STATE	ZIP CODE		SEX	EMPLOYER		HOME PHONE	WORK PHONE
DATE OF BIRTH			SOCIAL SECURITY #			MARITAL STATUS		INDICATE # OF DEPENDENTS		
						()SINGLE ()MARRIED ()OTHER				
INSURED'S NAME:LAST			FIRST		MI	ADDRESS				
CITY			STATE	ZIP CODE		SEX	EMPLOYER		HOME PHONE	WORK PHONE
DATE OF BIRTH			SOCIAL SECURITY #			MARITAL STATUS		INDICATE # OF DEPENDENTS		
						()SINGLE ()MARRIED ()OTHER				

CHILD INFORMATION										
DEPENDENT LAST NAME (IF DIFFERENT)			FIRST NAME		MI	2ND DEPENDENT LAST NAME (IF DIFFERENT)			FIRST NAME	
DOB	SEX	RELATIONSHIP	SOCIAL SECURITY NO.			DOB	SEX	RELATIONSHIP	SOCIAL SECURITY NO.	
EMPLOYER OR SCHOOL					EMPLOYER OR SCHOOL					
3RD DEPENDENT LAST NAME (IF DIFFERENT)			FIRST NAME		MI	4TH DEPENDENT LAST NAME (IF DIFFERENT)			FIRST NAME	
DOB	SEX	RELATIONSHIP	SOCIAL SECURITY NO.			DOB	SEX	RELATIONSHIP	SOCIAL SECURITY NO.	
EMPLOYER OR SCHOOL					EMPLOYER OR SCHOOL					

INSURANCE COMPANY INFORMATION										
NAME OF PRIMARY INSURANCE COMPANY					NAME OF SECONDARY INSURANCE COMPANY					
ADDRESS					ADDRESS					
CITY	STATE	ZIP	TELEPHONE		COPAY	CITY	STATE	ZIP	TELEPHONE	
GROUP NAME OR #	EFFECTIVE DATE	ID #	WELL	SICK	GROUP NAME OR #	EFFECTIVE DATE	ID #	WELL	SICK	
NAME OF INSURED IF THE RESP PARTY IS NOT THE INSURED			SEX	DATE OF BIRTH	NAME OF INSURED			SEX	DATE OF BIRTH	
INSURED ADDRESS			RELATION TO PATIENT		INSURED ADDRESS			RELATION TO PATIENT		

I understand and agree that (regardless of my insurance status) I am responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I authorize the release of any medical information necessary to process claims on my behalf. I permit a copy of this authorization to be used in place of the original.

I request payment from my insurance to be made directly to DeVito & Alvarado Pediatric Associates, PLLC (when they accept assignment). If the insurance check is mailed to me instead of the doctor, I will send the check within one week or be charged interest.

I certify that the above information I have reported is correct. I have received a copy of the office HIPAA policy.

The new health insurance portability act has limited us with regard to what information in your medical records can be shared with any other persons except you. Please initial what you will allow us to do for you. You may revoke your consent at any time, in writing, to our office. DeVito & Alvarado Pediatric Associates, PLLC may:

_____ Speak with my family members/spouse about my medical condition, lab and x-ray results or treatment plans.

Please give family member name and relationship to you: _____

_____ Telephone my home to confirm appointments _____ Fax test results to other physicians who are participating in my care

_____ Leave messages on my home machine or with family member _____ Leave messages at work for me to return your call only

Whom may we thank for referring you? _____

TAKEN BY: _____

PARENT/GUARDIAN SIGNATURE	RELATIONSHIP	DATE
---------------------------	--------------	------