Office Use Only

Date_____Doctor_____Acct#_____M____F_____E-script_____

PATIENT (CHILD) FINANCIAL INFORMATION

PATIENT (CHILD) NAME_____
LAST FIRST MI
DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY_____/_____/_____

MAILING ADDRESS_____
Number and Street City, State, Zip+4 digit code
HOME PHONE_____PARENT CELL_____E-MAIL_____

PEDIATRICIAN OR FAMILY DOCTOR_____CITY OF LOCATION_____

INSURANCE INFORMATION

PRIMARY INS_____INSURED'S NAME_____
SECOND INS_____INSURED'S NAME_____

PARENT INFORMATION

FATHER'S NAME_____DOB____/____/_____SS# ____/_____/_____

ADDRESS IF DIFFERENT THAT ABOVE_____

EMPLOYER_____EMPLOYER PHONE_____

EMPLOYER ADDRESS_____

MOTHER'S NAME_____DOB____/____/_____SS#_____/_____/_____

ADDRESS IF DIFFERENT THAT ABOVE_____

EMPLOYER_____EMPLOYER PHONE_____

EMPLOYER ADDRESS_____

If your child has insurance through a step-parent/guardian, please provide the following information
INSURED'S NAME_____DOB____/____/_____SS# ____/_____/_____
ADDRESS IF DIFFERENT THAT ABOVE_____
EMPLOYER_____EMPLOYER PHONE_____
EMPLOYER ADDRESS_____

Preferred Pharmacy_____Location_____
EMERGENCY CONTACT _____PHONE_____RELATIONSHIP_____

I authorize and release any medical information necessary for my child to process any claims. I authorize payment of medical benefits to the undersigned physician and agree that I am responsible for any balance of my child's account for services rendered. By signing this document, I will be the responsible party for my child unless other arrangements have been made with AIAMG's billing department.
Signature_____Date:_____