PATIENT INFORMATION

THANK YOU FOR CHOOSING OUR OFFICE! In order to serve you properly, we need the following information. Please Print. All information will be confidential.

Patient's Legal Name (Last)_____(First)_____(MI)_____

Preferred First Name: _____ SSN_____

Birth Date_____ ❍ Male ❍ Female

Address _____City_____ State ____ Zip_____

Home Phone#_____ Cell Phone#_____

Email Address:_____

Race: ❍ White ❍ Asian ❍ Hawaiian ❍ Pacific Islander ❍ African American ❍ American Indian ❍ Alaska Native

Language: ❍ English ❍ Spanish ❍ Hmong ❍ Other

Ethnicity: ❍ Not Hispanic/Latino ❍ Hispanic/Latino

Appointment Reminders: ❍ Telephone Call ❍ Text Message *(Message & data rates may apply)* ❍ Patient Portal/Email

Parent's Name_____Employer_____Cell Phone _____

Parent's Name_____Employer_____Cell Phone _____

Emergency Contact Name: _____ Phone Number _____

How did you hear about OakLeaf Pediatrics? Friend, Radio, Television, Internet, Phonebook or Other:_____

RESPONSIBLE PARTY

Name of person responsible for this account _____Relationship to Patient _____

Address_____Home Phone _____

Birth Date_____Employer_____ Work Phone _____

INSURANCE INFORMATION *(Required, unless you are self-pay.)*

Primary Insurance _____ID #_____Group #_____

Policy Holder_____ Employer_____Work Phone_____

Relationship to Patient _____Birth Date _____SSN_____

Secondary Insurance _____ID # _____Group #_____

Policy Holder_____ Employer_____Work Phone_____

Relationship to Patient _____Birth Date _____SSN_____

Amounts are due in full upon receipt of our statement. Although some payment arrangements may be available, you are urged to use your own bank or credit union to finance extended payments.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to understand your benefits and coverage and to obtain proper certification when needed. It is also your responsibility to pay any deductible, co-insurance, or any other balance not paid by insurance.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the disclosure of portions of my medical record.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to OakLeaf Clinics, SC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as 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.

***Signed:**_____ **Date:** ___/___/___*