PEDIATRIC INFORMATION

PATIENT NAME _____ _____
DATE OF BIRTH AGE

ADDRESS _____ MALE / FEMALE
STREET CITY ST ZIP

HOME PHONE _____ PATIENT'S SOCIAL SECURITY # _____

MOTHER'S NAME _____ FATHER'S NAME _____

CELL PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ DATE OF BIRTH _____

S S # _____ S S # _____

EMPLOYER _____ EMPLOYER _____

ADDRESS _____ ADDRESS _____

PHONE _____ PHONE _____

REFERRING DOCTORS NAME: _____

PEDIATRICIAN'S NAME _____ PHONE _____

ADDRESS _____
STREEET CITY ST ZIP

WOULD YOU LIKE YOUR RECORDS MAILED TO THE ABOVE PEDIATRICIAN? YES NO

REFERRED BY: PHONEBOOK ANOTHER PATIENT HOSPITAL ER ANOTHER DOCTOR

MEDICAL INFORMATION

WHAT CONDITION ARE YOU BEING SEEN FOR? _____
PLEASE CIRCLE RIGHT LEFT

DATE OF FIRST SYMPTOMS OR ACCIDENT _____ STATE OF ACCIDENT _____

IF ACCIDENT, PLEASE DESCRIBE IN DETAIL _____

_____

WERE CURRENT X-RAYS TAKEN? YES NO WHERE _____ WHEN _____

PLEASE TURN THE PAGE TO COMPLETE INSURANCE & SIGNATURE REQUIREMENTS

PRIMARY INSURANCE

COMPANY NAME _____

ADDRESS _____
STREET CITY ST ZIP

GUARANTOR NAME (POLICY HOLDER) _____

RELATIONSHIP TO PATIENT SELF_____ SPOUSE _____ DEP CHILD _____ OTHER_____

CERTIFICATE OR POLICY NUMBER _____

GROUP NUMBER _____ PLAN NUMBER _____

SECONDARY INSURANCE

COMPANY NAME _____

ADDRESS _____
STREET CITY ST ZIP

GUARANTOR NAME (POLICY HOLDER) _____

RELATIONSHIP TO PATIENT SELF_____ SPOUSE _____ DEP CHILD _____

CERTIFICATE OR POLICY NUMBER _____

GROUP NUMBER _____ PLAN NUMBER _____

AUTO INSURANCE INFORMATION

IF AUTO RELATED PLEASE COMPLETE

INSURANCE COMPANY NAME _____

ADDRESS _____
STREET CITY ST ZIP

PHONE NUMBER_____ ADJUSTOR NAME _____

CLAIM NUMBER _____ DATE OF ACCIDENT _____

I AUTHORIZE TRI-COUNTY ORTHOPEADICS, P.A., TO RELEASE ANY AN ALL INFORMATION CINCERNING THE MEDICAL CONDITION OF THE MINOR LISTED ABOVE, TO MY INSURANCE COMPANY OR ATTORNEY. I ALSO AUTHORIZE AND DIRECT THE INSURANCE COMPANY TO PAY DIRECTLY TO TRI-COUNTY ORTHOPEADIC, P.A., ALL CLAIMS SUBMITTED BY THEM FOR PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT BY SIGNING, I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES/SUPPLIES PROVIDED BY TRI-COUNTY ORTHOPEADIC, P.A., REGARDLESS OF ANY INSURANCE OR THIRD PARTY LIABILITY.

_____ _____
SIGNATURE DATE