KidMed
Feel better.

KidMed
Demographic Data

First Name _____	**Last Name** _____	Date:
SS #	**Date of Birth**	Male [ ] Female [ ]
Parent/Guardian Name:	**Phone Number**	
email address:		

How were you referred to our Practice? [ ]Friend/Family [ ]Insurance Company [ ] Internet
[ ] MD _____ [ ] Yellow Pages [ ]Print Ad [ ] Other_____

Race Ethnicity: [ ] White, Non-Hispanic [ ] Black, Non-Hispanic [ ] Hispanic [ ] Asian
[ ] Native American [ ] Native Hawaiian and Other Pacific Islander [ ] Other:

Address:		City	
State	ZIP	Home Phone:	Cell:

Employed? N [ ] Y [ ] Occupation: Work Number:
Marital Status: Married [ ] Divorced [ ] Widow/er [ ] Single [ ] Religion:

Who is financially Responbile: Self [ ] Other [ ] Name:
Address if not same as Patient:

Relationship:	Employed? N[ ] Y[ ] Name of employer:	
Home Phone:	Cell Phone:	Work Phone

Do you have Insurance? N [ ] Y [ ] Name of Company:

Policy Holder Number:	Group Number:	Eligibility Date:
Are you Policy Holder? Y[ ] N [ ] Subscriber Name:		Date of Birth
Address if different from Patient:		
Secondary Insurance? N[ ] Y[ ] Name of company:		
Are you Subscriber? Y[ ] N [ ] Subscriber Name:	Date (	Date of Birth:
Address if different from Patient:		
Policy Holder Number:	Eligibility Date:	

Additional Emergency Contact: Name:		Relationship:
Address if different from Patient:		
Home Phone:	Cell Phone:	Work Phone:

I understand that if any of the above information changes that it is my responsibility to provide (Practice) with a written update of information indicating all necessary changes

I understand that my primary insurance company will be billed for me but that all co-pays, co-insurance, non-covered items and deductible amounts are due at the time of service. I also understand that if my insurance company denies a charge for any reason, I will be billed and ultimately responsible for that charge. In addition, if a claim is disputed by the insurance company for any reason, and payment has not been made in a timely manner, I will be responsible for the payment of the charges until the dispute has been resolved and the insurance company makes payment on the charges in question. Lastly, I authorize insurance benefits to be paid directly to the physician and the release of any medical records that may be required by the insurance company in order to pay out those benefits. This assignment of benefits is irrevocable and a photo static copy shall be considered as legal and binding as the original. In event of default for any reason, parent/guardian is responsible for any and all attorney fees, collection fees and all courts costs.

Responsible Party (Pint):	
Signature Responsible Party:	Date
Relationship:	