Emmason Pediatric & Family Clinic

ADULT INSURANCE INFORMATION

Reason for your visit: ____ *Date:* __________________

*Name (Last):*_________________________ *(First) :*_____________________*(Middle):*_______________________

Address: ____ *(*APT):________________________

City: __________________________________ State: ______________________ Zip: _____________________

Home Phone#:__________________________ Cell: ________________________ Work: __________________

SS#:______________________________Date Of Birth: ________________________ Age: __________________

EMPLOYER: __________________________________ Address: ____

Occupation: ____

Marital Status: M______ S______ D______ W______ Sex: M_____ F____

Spouse's Name:___________________________ SS#:_____________________ DOB:________________________

Spouse's Employer:____ Address:______________________________

Children's Names Date Of Birth Social Security#

____ ____

____ ____

Emergency Contact:___________________________________ Phone#:___________________________________

INSURANCE NAME: ____

INSURANCE ID #: ______________________________________**GROUP #:** ________________________________

INSURED'S NAME: _______________________________________ **EMPLOYER:** ____________________________

INSURANCE PHONE #: ____

Acknowledgement & Authorization

I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever medicine, conduct of laboratory, x-ray, or other studies that may be used by the attending medical provider or her qualified designee. I acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service, unless other arrangements are made with the office staff. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Emmason Pediatric and Family Clinic will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable time. I authorize Emmason Pediatric and Family Clinic to release my information as required by my insurance or third party payor (including workers compensation) for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse, and/or mental health issues. I also authorize Emmason Pediatric and Family Clinic to bill my insurance or third party payer, and receive payment directly from them for services rendered to me. A photo copy of this authorization shall be deemed as valid as the original.

Signature (Patient or Guardian):____Date:__________________

(Legal Guardian does not include step-parent unless authorized by the court)