

# Nuby Pediatrics P.A.

Jan-06

## Patient Information:

Patient's Name (First, Middle, Last)			Home Phone#	Cell Phone#
Patient's Address			City, State, Zip	
Date of Birth:	Age	Social Security #	Sex: M F	Student Status: Full-time / Part-time / None

## Parent Information:

Father's Name		Address	Phone #	
Date of Birth:	Social Security #	Employer	Employer Phone #	
Mother's Name		Address	Phone #	
Date of Birth:	Social Security #	Employer	Employer Phone #	

## Insurance Information:

<b>Primary</b> Insurance Co. Name		Address	Phone#
Policy or ID #	Group #	Relationship to Patient: <b>Self</b> <b>Child</b> <b>Other</b>	
Insured's Name	Insured's Social Security #	Insured Date of Birth	
<b>Secondary</b> Insurance Co. Name		Address	Phone#
Policy or ID #	Group #	Relationship to Patient: <b>Self</b> <b>Child</b> <b>Other</b>	
Insured's Name	Insured's Social Security #	Insured Date of Birth	

Who is financially responsible for payment?
How were you referred to our office?

## Medical Information:

Allergies to any medications? <b>Yes</b> <b>NO</b> If yes list medications:	
Latex Allergies? <b>Yes</b> <b>No</b>	List any medications your child is taking:
Reason for Visit:	Pharmacy Preference:
Signature (Parent or Guardian):	Date:

### Assignment of Benefits & Authorization for Release of Medical Records

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicaid, Medicare, private insurance and any other plan to Dr. Marquis Nuby. 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 medical information including hospital records in the assignee's possession to my insurance company, attorney or employer, who may have responsibility toward securing payment of my account, including Medicare, where applicable.

SIGNATURE of RESPONSIBLE PARTY \_\_\_\_\_ Date \_\_\_\_\_

Signed by (please print) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_