Patient Information Form – Ivy Children's Clinic

Patient Full Name: ____

Date of Birth: ______________________ Sex: ________

Patient's SSN: ______________________________

Mother's Name: ______________________ Father's Name: ______________________

Address: ____

____

Phone Number: Work______________ Home______________ Cell______________

Email Address: ______________________________

Portal Access: ______________________________

Preferred Method of Contact: (Circle one) Work Phone Home Phone Cell Phone Email Portal

Emergency Contact Name: ______________________________

Emergency Contact's Relationship to patient: ______________________________

Emergency Contact's Phone Number: ______________________________

Guarantor Name (Person responsible for bill): ______________________________

Guarantor's Date of Birth: ______________________ Sex: ______________

Guarantor's SSN: ______________________Relationship to Patient: ______________

Guarantor's Address (If different from the patient):______________________________

____

Primary Insurance: ______________________________

Subscriber's Name: ______________________________

Subscriber's Date of Birth: ______________________________

Subscriber's Insurance ID: ______________________________

Member's ID: ______________________ Group ID: ______________________

Secondary Insurance: ______________________________

Subscriber's Name: ______________________________

Subscriber's Date of Birth: ______________________________

Subscriber's Insurance ID: ______________________________

Member's ID: ______________________ Group ID: ______________________

Preferred Pharmacy (Address, Phone Number and/or Cross Street):

____

PLEASE READ CAREFULLY, INITIAL, AND SIGN AS INDICATED

I AUTHORIZE Ivy Children's Clinic to render medical care to my child ________. I AUTHORIZE Ivy Children's Clinic to file my health insurance and ASSIGN any benefits payable to Ivy Children's Clinic________. I UNDERSTAND AND ACKNOWLEDGE that I am ultimately responsible for any fees incurred for services provided to my child (regardless of insurance status). Patient responsibility amounts are due in full at the time services are provided. This may include but is not limited to co-payments, co-insurance or account balances ________. I UNDERSTAND AND ACKNOWLEDGE that if I do not have insurance, I am responsible for any fees incurred for services rendered ________. I AGREE AND ACKNOWLEDGE that it is my responsibility to notify Ivy Children's Clinic immediately of any changes in my insurance ________.

Signature: ________________________________ Relationship: _________________________ Date: ________________