# SEA ISLAND PEDIATRICS
# PATIENT INFORMATION SHEET

**PATIENT INFORMATION** TODAY'S DATE ____/____/____

PATIENT _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SOCIAL SEC. # _____ SEX _____ RACE _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____

**MOTHER/LEGAL GUARDIAN'S INFORMATION**

MOTHER'S NAME _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SOCIAL SEC. # _____ RACE _____

DRIVER'S LICENSE # _____ STATE _____ HOME PHONE (____) _____

ALTERNATE PHONE (____) _____ WORK PHONE (____) _____ EXT _____

EMPLOYER _____

EMPLOYMENT ADDRESS _____
CITY STATE ZIP

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED

**FATHER'S INFORMATION**

FATHER'S NAME _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SOCIAL SEC. # _____ RACE _____

DRIVER'S LICENSE # _____ STATE _____ HOME PHONE (____) _____

MAILING ADDRESS IF DIFFERENT THAN ABOVE _____

CITY _____ STATE _____ ZIP _____

ALTERNATE PHONE (____) _____ WORK PHONE (____) _____ EXT _____

EMPLOYER _____

EMPLOYMENT ADDRESS _____
CITY STATE ZIP

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY _____ POLICY # _____

EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ POLICY HOLDER'S DATE OF BIRTH _____

SECONDARY INSURANCE COMPANY _____ POLICY # _____

EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ POLICY HOLDER'S DATE OF BIRTH _____

****MEDICAID PATIENT'S WITH PRIMARY INSURACE IF APPLICABLE ARE REQUIRED TO PAY THEIR CONTRACTUAL COPAYMENTS AT TIME OF SERVICE****

EMERGENCY CONTACT _____ PHONE # _____
NAME OF PERSON WHO DOES NOT RESIDE AT YOUR RESIDENCE RELATIONSHIP

**********CONTINUED ON NEXT PAGE**********

PATIENT INFORMATION SHEET CONTINUED

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

## PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical of medical benefits directly to Sea Island Pediatrics, P.A. for any services furnished to me. I
Understand I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company any information concerning health care, treatment, or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

**SIGNATURE**_____ **DATE** _____

## MEDICAL SERVICES AUTHORIZATION

I authorize Sea Island Pediatrics, P.A. to give me reasonable and proper medical care by today's standards.

**SIGNATURE** _____ **DATE** _____

## PAYMENT AGREEMENT

It is the policy of Sea Island Pediatrics, P.A. that charges for services rendered by our physicians and staff including contractual co pays and deductibles are paid at time of service unless other formal arrangements have been made in advance with our business office.

For your convenience, Sea Island Pediatrics, P.A., will file electronic insurance claims; however, it will be your responsibility to provide our office with the necessary information and signed authorization for filing insurance. This information and authorization must be provided to our office at your first visit, accompanied with a copy of our health insurance card(s).

Arrangements for monthly payments may be made with our business staff for any patient account balance in excess of $200. A minimum payment is required each month to keep your account active. You are responsible for making the monthly payment by the 5th working day of each month whether or not a statement has been sent to you. Any patient's account that becomes delinquent (monthly payment not made within 30 days of the last payment) will be processed in our collections department, and the complete balance will become due immediately. In addition to the complete account balance you will also be responsible for all attorney fees, court costs, and a collection fee of 35% will also apply.

I agree to the above financial agreement for any services provided to me by Sea Island Pediatrics, P.A.

**SIGNATURE** _____ **DATE** _____