Lafayette Pediatrics

JUDICE, BOUSTANY, GRANT & CLARK

Patient Information Sheet

Patient Name______________________________**Phone#**________________

Siblings to Patient____

Patient

D.O.B._______________________ **Age**______ **Sex:** **Male** **Female**

Billing Address____**City/Zip**_______________________

Parent Information

Father:__________________________________ **Mother**__________________________________

Address__________________________________ **Address**__________________________________

City/Zip__________________________________ **City/Zip**__________________________________

Cell #_________________**Wk#**_______________ **Cell #**_________________**Wk#**_______________

Employer_________________________________ **Employer**_________________________________

Alternate Contact____

#1 INSURANCE INFORMATION

Ins. Co:__________________________________

Insured Name______________________________

DOB________________**SS#**________________

Relationship to Patient_________________________

ID#_____________________**G#**______________

#2 INSURANCE INFORMATION

Ins Co:__________________________________

Insured Name______________________________

DOB________________**SS#**________________

Relationship to Patient_________________________

ID#_____________________**G#**______________

I hereby assign, transfer and set over to Michael K. Judice, M.D., LTD. all of my interests to medical reimbursement of benefits under my insurance policy. I authorize the release of medical information needed to determine these benefits. I understand that I am financially responsible for all charges not covered by my insurance. I am responsible for all fees, including legal or other costs incurred in the collection of this account, should it become delinquent. There will be a charge for all NSF checks.

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Patient's or Guardian's Signature **Date**