

**SUGAR LAKES FAMILY PRACTICE  
PATIENT INFORMATION  
PEDIATRIC**

**DATE:** \_\_\_\_\_ **DR:** \_\_\_\_\_ **ACCT#:** \_\_\_\_\_

**NAME(LAST):** \_\_\_\_\_ **(FIRST):** \_\_\_\_\_ **(MIDDLE):** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **APT#:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**HOME TELEPHONE#( )** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **MALE:** \_\_\_\_\_ **FEMALE:** \_\_\_\_\_

**MOTHER'S NAME:** \_\_\_\_\_ **MOTHER'S WORK#** \_\_\_\_\_

**FATHER'S NAME:** \_\_\_\_\_ **FATHER'S WORK#** \_\_\_\_\_

**SIBLINGS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ **PHONE#** \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ **PHONE#:** \_\_\_\_\_

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**INSURANCE NAME:** \_\_\_\_\_

**INSURANCE ID#:** \_\_\_\_\_ **INSURANCE GROUP#** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

**INSURANCE ADDRESS:** \_\_\_\_\_

**INSURANCE TELEPHONE#( )** \_\_\_\_\_

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO SUGAR LAKES FAMILY PRACTICE FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY. I ALSO AUTHORIZE A RELEASE OF MY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT. I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF REPORTS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFIT BE MADE ON MY BEHALF. A PHOTOCOPY PF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL.

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PARENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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

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