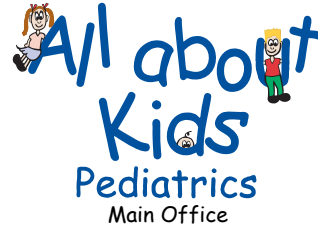


WELCOME



8500 Commodity Circle • Orlando, Florida 32819
(407) 354-0717 Fax (407) 354-5436

PATIENT INFORMATION

Today's Date ____/____/____

Child's Legal Name _____

SS# ____-____-____

Nickname (if any) _____

Age ____ Date of Birth ____/____/____ Sex _____

Email address for appointment confirmation:

Names of your other children who are patients here

Mother/Legal Guardian's Name

Date of Birth ____/____/____ SS# ____-____-____

Home Address _____

City State Zip

Home Phone (____) ____-____

Cell Phone (____) ____-____

Place of Employment _____

Work Phone (____) ____-____ Ext _____

Father/Legal Guardian's Name

Date of Birth ____/____/____ SS# ____-____-____

Home Address _____

City State Zip

Home Phone (____) ____-____

Cell Phone (____) ____-____

Place of Employment _____

Work Phone (____) ____-____ Ext _____

If parents are divorced who has legal custody of child?

How did you learn about our practice?

Who was your obstetrician?

Who if anyone other than the responsible party has permission to be involved in your child's medical treatment including bringing them in for visits?

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Insurance Assignment and Releases

I, the undersigned hereby assign, transfer and set over to All about Kids Pediatrics all my rights, title and interest in and to medical and/or surgical benefit payments to which I am entitled resulting from the medical and/or surgical services performed for me by All about Kids Pediatrics and I direct my insurance company to pay any and all such entitlements directly to All about Kids Pediatrics.

Parent or Legal Guardian Responsible for Account

I authorize All about Kids Pediatrics to render medical care to my child. **I understand that all copays and deductibles are to be paid at the time of service.** In the event that my account becomes delinquent and must be turned over to a collection agency or attorney, I agree to pay any and all costs of collection including attorneys fees. In the event that my child is hospitalized, I authorize the release of any medical information necessary to process an insurance claim and I authorize payment of medical benefits directly to All about Kids Pediatrics. I understand that my insurance policy is a contract between myself and my insurance company and that I am financially responsible for charges not covered by the policy. I will assist in the collection of my insurance benefit should there be any delay in payment.

Parent or Legal Guardian Responsible for Account

I have received the attached sheet "All about Kids Pediatrics Financial Policy"

Parent or Legal Guardian Responsible for Account

I have received the attached "Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

Parent or Legal Guardian Signature