

- JOHN L. CLARK, M.D.
- ANN B. BUBENZER, M.D.
- ZULMA N. LARACUENTE, M.D.
- ROBERT C. CULPEPPER, M.D.



Childs Full Name: \_\_\_\_\_ Name Child is called: \_\_\_\_\_  
last first middle

Sex: \_\_\_ M \_\_\_ F D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street/box City State Zip

Parent/Guardian Telephone: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_

Parent/Guardian: Father \_\_\_\_\_  
last first middle

D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_

Mother \_\_\_\_\_  
last first middle

D.O.B.: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Company Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Sex: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ How is this patient related to subscriber? \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Company Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber Sex: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ How is this patient related to subscriber? \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Patient Drug Allergies: \_\_\_\_\_

Pharmacy Preferred: \_\_\_\_\_

List all children who have been patients of Premier Pediatrics:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\*\*\*\*\*Assignment of Benefits and Authorization for Information Release\*\*\*\*\*

- 1) I hereby assign and authorize payment of insurance benefits otherwise payable directly to Premier Pediatrics, for office or hospital services, which are not paid by me at the time of services.
- 2) I hereby authorize Premier Pediatrics to provide treatment for the patient listed above, and to release any and all information pertaining to office or hospital service rendered to me by said practice, including the diagnosis and treatment rendered to me by previous physicians, hospitals, or other medical facilities/personnel.
- 3) I understand that I am ultimately responsible for payment of any and all charges for treatment received and if this assigned claim is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full.

Parent/Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_