Child

Name: ______________ *Birth Date:* ___/___/___ *Sex:* ____ *Age:* ____

RESERVED

Social Security # ______________ *Child lives with: Mother* ______ *Father* ______ *Other* ______

Person to contact in an EMERGENCY: ______________ *Relationship* ______ (____) (________)

Siblings	*Social Security #*	*Birth Date*	*Sex*	*Age*
1.		/ /		
2.		/ /		
3.		/ /		
4.		/ /		

RESERVED

Parent / Guardian

Last Name: ______________ First Name: ______________ Home Phone: (____) (________)

Birth Date: ___/___/___ Sex: M / F Marital Status: Single / Married / Divorced / Widow / Partner Cell Phone: (____) (________)

Address: ______________ Apt. # ____ City: ______________ State: ____ Zip: ______

Employer: ______________ Work Phone: (____) (________) Ext.: ____

Employer Address: ______________ City: ______________ State: ____ Zip: ______

Social Security # ______________ Occupation: ______________

Parent / Guardian

Last Name: ______________ First Name: ______________ Home Phone: (____) (________)

Birth Date: ___/___/___ Sex: M / F Marital Status: Single / Married / Divorced / Widow / Partner Cell Phone: (____) (________)

Address: ______________ Apt. # ____ City: ______________ State: ____ Zip: ______

Employer: ______________ Work Phone: (____) (________) Ext.: ____

Employer Address: ______________ City: ______________ State: ____ Zip: ______

Social Security # ______________ Occupation: ______________

Insurance

Primary Insurance: ______________ Insurer's Name: ______________

Insurance I.D. # ______________ Group #: ______________ Relationship: ______________

Secondary Insurance: ______________ Insurer's Name: ______________

Insurance I.D. # ______________ Group #: ______________ Relationship: ______________

I HEREBY AUTHORIZE PHOENIX CHILDREN'S CENTER, LTD TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. IN THE EVENT THAT PAYMENT IS NOT MADE ON THIS ACCOUNT AND IT IS PLACED WITH A LICENSED COLLECTION AGENCY, I/WE AGREE TO PAY THE FEES OF THE COLLECTION AGENCY EQUAL TO A MAXIMUM OF 50% OF OUR OUTSTANDING BALANCE AT THE TIME THE ACCOUNT IS PLACED WITH THE AGENCY. INTEREST OF 10% PER YEAR WILL BE ACCRUED ON THE PRINCIPAL BALANCE. SHOULD LEGAL ACTION ALSO BE NECESSARY TO COLLECT THE ACCOUNT, I/WE AGREE TO PAY ATTORNEY'S FEES AND COURT COSTS INCURRED FOR COLLECTION.

INSURED SIGNATURE ______________ DATE ______

SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR: ______________ DATE ______