PEDIATRIC MEDICINE, P.A.

7922 EWING HALSELL DR., SUITE 440
SAN ANTONIO, TEXAS 78229-3726

PLEASE READ CAREFULLY AND PRINT CLEARLY
CHECK, CREDITCARD OR CASH PAYMENT IS REQUIRED FOR EACH VISIT

Patient's Name (Child) _____

__Male __Female Age _____ Date of Birth _____

Race: (Circle one) American Indian/Alaskan native/ Asian/ Native Hawaiian or other Pacific/ Black or African American/ White/ Hispanic/ Other

Ethnicity: (Circle one): Hispanic/ Non-Hispanic Email:_____

Preferred pharmacy/Address/Phone:_____

Father's Name _____ Date of Birth _____

Mother's Name (Maiden) _____ Date of Birth _____

Father's SS# _____Mother's SS# _____ Telephone _____

Address_____ Cell Phone _____

City _____ State _____ Zip Code _____

Father's Employer _____ Occupation _____

Telephone _____

Mother's Employer _____ Occupation _____

Telephone _____

Emergency Contact Name _____ Telephone _____

INSURANCE INFORMATION

Insured's Name _____ Employer's Name _____

Insurance Company (1) _____

Group Number _____ Policy Number _____

Address to which claims are sent _____

Insured's Name _____ Employer's Name _____

Insurance Company (2) _____

Group Number _____ Policy Number _____

Address to which claims are sent _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Michael A. Ozer, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as the original. I hereby authorize assignee to release all information necessary to secure payment. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

Signed _____ Date_____

I have read and understand, the Office Policies of PEDIATRIC MEDICINE, P.A.. I agree to comply with these policies as stated._____INITIALS