PATIENT INFORMATION — PLEASE PRINT

Name of Patient ____________________ Date ____________

Home Address ____________________

City ____________________ State ____________ Zipcode ____________

Home Telephone ____________________ Alternate Telephone ____________________

Date of Birth ____________ Sex M F Social Security Number ____________ Email Address ____________

Parent's Names ____________________

Mom's Work # ____________ Cellular ____________ Dad's Work # ____________ Cellular ____________

Person Financially Responsible for Patient ____________________ Relationship ____________

Emergency Contact ____________________ Relationship ____________ Telephone ____________

Whom May We Thank for Referring You ____________________

PRIMARY INSURANCE

Name of Insured ____________________ Relationship to Patient ____________

Address (if different from patient) ____________________

Insured's Date of Birth ____________ Social Security Number ____________

Insured's Employer ____________________ Work Telephone ____________

Insurance Plan Name ____________________

Policy Number ____________ Group Number ____________

Co – Pay ____________ Deductible ____________ Type of Plan Medicare HMO PPO Commercial

Are you familiar with coverage limitations of your plan? ____________________

SECONDARY INSURANCE

Name of Insured ____________________ Relationship to Patient ____________

Address (if different from patient) ____________________

Insured's Date of Birth ____________ Social Security Number ____________

Insured's Employer ____________________ Work Telephone ____________

Insurance Plan Name ____________________

Policy Number ____________ Group Number ____________

Co – Pay ____________ Deductible ____________ Type of Plan Medicare HMO PPO Commercial

Are you familiar with coverage limitations of your plan? ____________________

AUTHORIZATION FOR TREATMENT

I authorize Dr. Banks, Berry, Monde-Matthews/ or Tice to provide medical treatment for myself or my child or ____________________ (name of patient).

Signature ____________________ Relationship to Patient ____________

ASSIGMENT OF INSURANCE BENEFITS

I request that payment of authorized insurance benefits be made to me or on my behalf to My Kid's Doc - Southfield, PLLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the ____________________ (name of insurance company) and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.

Signed ____________________ Date ____________