

TODAY'S DATE: \_\_\_\_\_ CHILD'S PRIMARY CARE DR. \_\_\_\_\_

CHILD'S FULL NAME: \_\_\_\_\_ SEX: M or F

CHILD'S BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

WHO DOES THE CHILD LIVE WITH? MOM DAD GRANDPARENTS OTHER

**ALL OF THE FOLLOWING INFO IS NEEDED FOR PROPER BILLING**

FATHER'S NAME: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CELL: \_\_\_\_\_

CELL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WHO IS THE INSURANCE POLICY HOLDER? MOM DAD CHILD

NAME OF THE PRIMARY INSURANCE COMPANY? \_\_\_\_\_

CHILD'S ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

IS THERE A SECONDARY INSURANCE? Y N

NAME OF THE INSURANCE COMPANY: \_\_\_\_\_

WHO IS THE POLICY HOLDER? MOM DAD CHILD

CHILD'S ID#: \_\_\_\_\_ GROUP # \_\_\_\_\_

I, THE UNDERSIGNED, ASSIGN DIRECTLY TO SSIMED{ BILLING COMPANY}, ALL MEDICAL BENEFITS IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED TO MY CHILD{REN }. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_