PATIENT INFORMATION

CHILD'S NAME _____
(FIRST) (MIDDLE) (LAST)

DATE OF BIRTH _____ SEX _____

LANGUAGE _____ RACE _____ ETHNICITY (CIRCLE ONE) HISPANIC/LATINO NON HISPANIC/LATINO

ADDRESS _____

_____

CELL/HOME PHONE _____ SOCIAL SECURITY # _____

EMAIL _____

MOTHER / GUARDIAN'S NAME _____

MOTHER'S MAIDEN NAME _____

ADDRESS _____

CELL/HOME PHONE _____ EMAIL _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ WORK PHONE _____

FATHER / GUARDIAN'S NAME _____

ADDRESS _____

CELL/HOME PHONE _____ EMAIL _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ WORK PHONE _____

RELATIVE/FRIEND <u>NOT</u> LIVING WITH YOU, IN CASE OF EMERGENCY

NAME _____

CELL/HOME PHONE _____ WORK PHONE _____

AUTHORIZATION AND ASSIGNMENT:

I HEREBY AUTHORIZE **Children's Medical Group of Salisbury, PA** TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY CHILD'S ILLNESS AND TREATMENTS, AND HEREBY ASSIGN TO **Children's Medical Group of Salisbury, PA**, ALL PAYMENT FOR MEDICAL SERVCICES RENDERED TO MY CHILD. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSUANCE. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL. WHEN PAYMENT IS NOT MADE AS AGREED, ACCOUNT BALANCES MAY BE SENT TO OUTSIDE COLLECTION FIRMS FOR LEGAL COLLECTION ACTION. THE GUARANTOR OR RESPONSIBLE PARTY SHALL BE RESPONSIBLE FOR AND AGREE TO PAY ALL REASONABLE COLLECTION COSTS, INCLUDING, BUT NOT LIMITED TO, REASONABLE COLLECTION AGENCY FEES, ATTORNEY'S FEES AND COURT COSTS.

SIGNATURE _____ DATE _____

REVISED 05/14/24

_____ MYSIS
_____ AMAZING