



INFANTS • CHILDREN • ADOLESCENTS

301 Middletown Park Place, Suite C
Louisville, Kentucky 40243
Office: (502) 244-9858
Fax: (502) 244-9575

Date _____

Mother's Information:

Last Name First Name MI

Address / City / State / Zip

Home Phone _____ Cell Phone _____ Date of Birth _____ Age _____

Social Security Number _____

Employer _____ Employer phone _____

Employer's Address _____

Married _____ Separated _____ Widowed _____ Divorced _____ Single _____

Father's Information:

Last Name First Name MI

Address / City / State / Zip

Home Phone _____ Cell Phone _____ Date of Birth _____ Age _____

Social Security Number _____

Employer _____ Employer phone _____

Employer's Address _____

Married _____ Separated _____ Widowed _____ Divorced _____ Single _____

Patient Information:

Last Name First Name MI

Address / City / State / Zip

Phone _____ Sex M _____ F _____ Date of Birth _____ Age _____

Social Security Number _____ School _____

Contact in case of emergency Relationship Phones: Home Cell Work

Name of closest relative / friend not living with you Phone number

Insurance Information

Primary Insurance Company _____ Employer name _____

Subscriber _____ Subscriber's Birthdate _____ Sex _____

Policy Number _____ Group Number _____

Subscriber's relation to patient _____ Effective Date _____

Secondary Insurance Company _____ Employer name _____

Subscriber _____ Subscriber's Birthdate _____ Sex _____

Policy Number _____ Group Number _____

Subscriber's relation to patient _____ Effective Date _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

Name of insurance company/companies

And assign directly to Middletown Pediatrics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor/group may use my health care information and may disclose such information to the above named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end one year from the date signed below.

Signature of subscriber, parent, guardian or personal representative.

Please print name of subscriber, parent, guardian or personal representative.

Date

Relationship to subscriber

ALTERNATE GUARDIAN DESIGNATION

I, _____, authorize the following individual(s) to
(Please print)

accompany my child to Middletown Pediatrics for his/her examination in my absence:

I understand the alternate guardian “cannot” accompany the child for the initial office visit, administration of immunizations, well exams (i.e., physical, sport physical and camp physical), or ADD/ADHD visits.

Parent/Legal Guardian Signature and Date