FAMILY INFORMATION SHEET

PLEASE READ CAREFULLY AND PRINT CLEARLY

Patient's Name (Child): _____

DOB: _____ Age: _____ Male: _____ Female: _____

Referred by: _____

PARENT INFORMATION

Mother's Name: _____ DOB: _____

Father's Name: _____ DOB: _____

Home Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Father's Employer: _____

Work Phone: _____ Cell Phone: _____

Father's Social: _____ Driver's License No.: _____

Mother's Employer: _____

Work Phone: _____ Cell Phone: _____

Mother's Social: _____ Driver's License No.: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone: _____

Member #: _____ Group #: _____

Insured Name: _____ DOB: _____

Employer: _____ Effective Date: _____

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 G. Scott Cuming, M.D., P.A. This assignment will remain in effect until revoked by me in writing. A photo copy of this agreement is to be considered as valid as an original. I hereby authorize said 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: _____