

Minor Patient Information Sheet

Patient Name: _____
Last First MI

Mother's Name: _____
Last First MI

Address: _____

State ZIP

Address: _____

City State ZIP

Home Phone: _____ Birth Date: _____

Home Phone: _____ Wk. Phone: _____

Male Female SS #: _____ Birth Date: _____

SS #: _____

Father's Name & Employer: _____

Employer: _____

Address: _____

Pharmacy Name & Phone #: _____

_____ City State ZIP

Responsible Party Info: _____

Home Phone: _____ Work Phone: _____

Birth date: _____ SS #: _____

Employer: _____

Conditions For Filing Health Claims

Insurance claims are filed for you as a courtesy. All Ages Family Medicine will file with your primary and secondary insurance carriers. Any insurance check paid to you for services rendered by All Ages Family Medicine must be endorsed and forwarded to us.

Payment Policy: Accounts are due and payable upon receipt of services.

The Authorization Below Must Be Signed Before We Can File Any Claims

I authorize the release of medical information necessary for filing health claims for me by All Ages Family Medicine. I also authorize the insurance companies to make payment directly to this company. I agree to the payment conditions outlined above, and understand that any overpayment will be refunded to the appropriate party. I understand that I am financially responsible for services not covered by my insurance Co. after contractual adjustments.

PLEASE PROVIDE INSURANCE INFORMATION ALONG WITH A COPY OF YOUR INS. CARD

Date: _____ Card Holder Name: _____ DOB: _____

SS#: _____ Employer: _____

Insurance Company: _____ Phone: _____ ID# _____

Group #: _____ Spoke With: _____ Deductible: _____ Copay: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Claims Phone #: _____ Effective Date: _____ Term Date: _____ PCP: _____

PCP Phone #: _____ Capitated: Yes No Hospital: _____

Lab: _____ X-ray: _____ Pre Ex Conditions: _____

Rate Code/Network: _____ Out of Network Benefits: _____

Special Services requiring prior auth: _____ Prior auth over \$ _____

Secondary Insurance Carrier

Date: _____ Card Holder Name: _____ DOB: _____

SS#: _____ Employer: _____

Insurance Company: _____ Phone: _____ ID# _____

Group #: _____ Spoke With: _____ Deductible: _____ Copay: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Claims Phone #: _____ Effective Date: _____ Term Date: _____ PCP: _____

PCP Phone #: _____ Capitated: Yes No Hospital: _____

Lab: _____ X-ray: _____ Pre Ex Conditions: _____

Rate Code/Network: _____ Out of Network Benefits: _____

Special Services requiring prior auth: _____ Prior auth over \$ _____

Parent / Guardian Signature: _____ Date: _____