Hospital _____
1st appt. _____
Time _____
Location _____

RIVER HILLS PEDIATRICS

602 S. FT. THOMAS AVE.
FT. THOMAS, KY 41075

7831 ALEXANDRIA PIKE
ALEXANDRIA, KY 41001

DATE _____

Please print clearly.

PATIENT INFORMATION

CONFIDENTIAL

PATIENT NO. _____

PATIENT'S NAME _____ BIRTHDATE _____ SEX M ☐ F ☐

PATIENT'S NAME _____ BIRTHDATE _____ SEX M ☐ F ☐

PATIENT'S NAME _____ BIRTHDATE _____ SEX M ☐ F ☐

PATIENT'S NAME _____ BIRTHDATE _____ SEX M ☐ F ☐

RESPONSIBLE PARTY / CARETAKER

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ SEX M ☐ F ☐

MOTHER'S NAME _____ BIRTHDATE _____ SS# _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

FATHER'S NAME _____ BIRTHDATE _____ SS# _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

PATIENT'S ADDRESS _____ CITY _____ ST _____ ZIP _____

INSURANCE INFORMATION

NAME OF PERSON WHO CARRIES INSURANCE _____ RELATIONSHIP TO PT _____ SEX M ☐ F ☐

BIRTHDATE _____ SOCIAL SECURITY # _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE CO. _____ ID# _____ GROUP # _____ UNION OR LOCAL # _____

INSURANCE CO. ADDRESS _____ CITY _____ ST _____ ZIP _____

COPAY AMOUNT _____ EFFECTIVE DATE _____

DO YOU HAVE ANY ADDITIONAL INSURANCE: YES ____ NO____ IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PT _____ SEX M ☐ F ☐

BIRTHDATE _____ SOCIAL SECURITY # _____

NAME OF EMPLOYER _____ WORK PHONE _____

INSURANCE CO. _____ ID# _____ GROUP # _____ UNION OR LOCAL # _____

INSURANCE CO. ADDRESS _____ CITY _____ ST _____ ZIP _____

COPAY AMOUNT _____ EFFECTIVE DATE _____

Patients who carry insurance should know all professional services furnished are charged directly to the responsible party, who is personally responsible for payment. We will prepare any necessary reports and forms to assist in making collections from the insurance company. However, we cannot render services on the assumption that our charges will be paid by an insurance company. Most misunderstandings about insurance coverage can be avoided if you understand what your policy provides.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PARAGRAPH.

SIGNED _____

I authorize payment of medical benefits to River Hills Pediatrics for medical services rendered by them. I authorize the release of any information necessary to process insurance claims or to secure payment. A photocopy of this authorization is to be considered as valid as an original. This authorization will remain in effect until revoked by me in writing.

SIGNED _____