Jercinovic Pediatrics

ASSIGNMENT OF INSURANCE BENEFITS

All information must be filled out in full

PLEASE PRINT

Today's Date:				
PATIENT INFORMATION				
Patient's Last Name:	First:	Middle:	Date of Birth:	Marital status of Parents: Married-Divorced-Separated-Not married
Street Address:			Home Phone:	
City:	State:	Zip	Sex: □M □ F	
Please list names and dates of birth for all other children who are covered by insurance/s listed below:				
Patient's Name:		Date of Birth:	Sex: □M □ F	
Patient's Name:		Date of Birth:	Sex: □M □ F	
Patient's Name:		Date of Birth:	Sex: □M □ F	
Patient's Name:		Date of Birth:	Sex: □M □ F	
Patient's Name:		Date of Birth:	Sex: □M □ F	
Patient's Name:		Date of Birth:	Sex: □M □ F	
Mother's/Guardian's Name:		Date of Birth:	Social Security Number:	
Address (If different)		Employer:		
Father's /Guardian's Name:		Date of Birth:	Social Security Number:	
Address (If different)		Employer:		
Mother's Cell Phone:		**Father's Cell Phone:**		

INSURANCE INFORMATION				
(Please give your insurance card to receptionist for scanning) **Please note: In case of divorce, it is our policy that responsibility of any amount left owed after insurance has paid will be the responsibility of the parent who brings the child for their appointments.**				
Primary Insurance Name:			**Effective Date:**	
Policy Holder's Name:	**Social Security #:**	**Date of Birth:**	**Relationship to Child:**	
Insurance Company Address:	City:	State:	Zip Code:	Insurance Telephone:
Employer:	Policy/ID#:	Group:		Co-pay Amount $:
Secondary Insurance Name (If applicable)			**Effective Date:**	
Policy Holder's Name:	**Social Security #:**	**Date of Birth:**	**Relationship to child:**	
Insurance Company Address:	City:	State:	Zip Code:	Insurance telephone:
Employer:	Policy/ID#:	Group #:		Co-pay Amount$:

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENTS OF BENEFITS

The above information is true to the best of my knowledge. I authorize the release of medical information to the listed insurance company/companies if so requested by them. I authorize my insurance benefits be paid directly to Jercinovic Pediatrics, Ltd. I understand that I am financially responsible for any services that are not covered and/or paid by the insurance policy/policies. I also authorize Jercinovic Pediatrics or insurance company to release any information required to process my claims.

Parent/Guardian Name: **Date:**

Parent/Guardian signature: **Date:**