Sunshine Pediatric Therapy, LLC

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Parent Information (please print)

Gaurdian:_____Address:_____
City/State/Zip:_____
Home Phone#:_____ Alternate Phone#:_____
Email Address:_____ Preferred Contact: Phone or Email
Referring Physician/Pediatrician Name:_____
Physician's Phone#:_____ Physician Fax#:_____
How did you hear about us?_____

Patient Information

Child's Full Name:_____ Date of Birth:_____
Social Security Number:_____-_____-_____
Address:_____ City/State/Zip:_____
Age:_____ Sex: M F
Diagnosis:_____

Insurance Information (Please fill out in full and sign so claims can be sent to your insurance company.)

Policy Holder's Name:_____
Policy Holder's Employer:_____
Insurance Company:_____
Insurance Company Address:_____ Phone#:_____
Policy Holder's Date of Birth:_____
Policy Holder's Social Security#:_____
ID#:_____ Group#:_____

Secondary Insurance Information (if applicable)

Policy Holder's Name:_____
Policy Holder's Employer:_____
Insurance Company:_____
Insurance Company Address:_____ Phone #:_____
Policy Holder's Date of Birth:_____
Policy Holder's Social Security#:_____
ID#:_____ Group#:_____

AUTHORIZED PERSON'S SIGNATURE: I hereby assign the medical benefits to which I am entitled from private insurance and other health plans to Sunshine Pediatric Therapy, LLC. A photocopy of this assignment is to be considered as valid as an original. I authorize Sunshine Pediatric Therapy, LLC to release information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signed:_____ Date:_____