Drs. Miller & Madden, P.A.
1011 Frederick Road
Catonsville, MD 21228

Patient's Name: _____ Male/Female (circle)
First Middle Last
Patient's Social Security Number: _____ **Birth Date**: _____

Mother's Name: _____ Home Phone #: _____
Social Security Number: _____ Work Phone #: _____
Cell Phone #: _____
Home Address: _____ Email: _____
Street Apt #
_____
City State Zip

Name of Employer: _____ Mother's Date of Birth: _____

Father's Name: _____ Home Phone #: _____
Social Security Number: _____ Work Phone #: _____
Cell Phone #: _____
Home Address: _____Email: _____
Street Apt #
_____
City State Zip

Name of Employer: _____ Father's Date of Birth: _____

Insurance Information: (Please give your card to front desk to photocopy)

Insurance Company: _____ Member ID#: _____
Subscriber Name: _____ Group ID#: _____
Ins. Co. Address: _____

Emergency Contact:
Please list the name and phone number of the person we should contact in the event of an emergency (other than mom and dad):
Name: _____ Relationship: _____ Phone #: _____

Statement of authorization for treatment:
I hereby authorize the physicians employed by Drs. Miller & Madden, P.A. to submit for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to Drs. Miller & Madden, P.A. I certify that the information I have reported with regard to my insurance coverage is correct and I further authorize the release of necessary information, including medical information, for this visit or any related claims to my insurance company. I permit a copy of this authorization to be used in place of an original. I understand that payment in full or a copay (if applicable) is expected at the time service is rendered. I also understand that I will be held responsible for any balance on my child's account if the insurance does not pay. In addition, I authorize Drs. Miller and Madden and their staff to administer necessary preventative and medical care to my child.

Date Updated	**Initials**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of Parent/Legal Guardian **Date**

Who referred you to our practice? _____