Growing Healthy Children
Growing Children Happy and Healthy

**PLEASE FILL OUT COMPLETELY**

## Patient Information

Name: _____ (First / Middle / Last)
Address: _____
City: _____
State: _____
Zip Code: _____
Phone: Home: _____
Cell: _____
Work: _____

## Patient Profile

Patient ID#: _____ Sex: ❑ M ❑ F
Date of Birth: _____
Patient's SS#: _____
List all children you will be bringing to this office:
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

## Guarantor (Insurance Policy Holder)

Name: _____
Address: _____
_____
City: _____
State: _____
Zip Code: _____

## Guarantor's Employment

Employer: _____
Employer Phone #: _____
Social Security #: _____
Date of Birth: _____

## Primary Insurance

Insurance Company: _____
Insurance Address: _____
Insurance Phone #: _____
Insurance ID #: _____
Group #: _____

Emergency Contacts:
Name: _____
Phone #: _____
Name: _____
Phone #: _____

## Parent Information

Father
Name: _____
Address: _____
SS#: _____
DOB: _____

Mother
Name: _____
Address: _____
SS#: _____
DOB: _____

## ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Growing Healthy Children all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I request and give consent to any physician to provide and perform such medical/surgical care, test, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician.

_____ _____
Signature of Parent / Guardian Date