Carroll Children's Center

Patient's Name ________________ Sex: M F Birthday ________________

Home Address ________________ Box # ______ Home Phone (__) ________________

City, State, ZIP ________________

Sibling Names, plus birth dates ________________

Patient lives with: (circle who) Both Mother Father Other Grandparent Foster Home

Mother's Name/Guardian ________________ Home Phone (__) ________________

Mother's Maiden Name ________________

Address if different from Patient ________________

Employer ________________ Work Phone (__) ________________

Birthday ________________ Cell Phone (__) ________________

Father's Name/Guardian ________________ Home Phone (__) ________________

Address if different from Patient ________________

Employer ________________ Work Phone (__) ________________

Birthday ________________ Cell Phone (__) ________________

Primary Insurance (we submit only if we participate) Policyholder ________________

Name of Ins. Co. ________________ Policy # ________________ Group # ________________

Secondary Insurance (we submit only if we participate) Policyholder ________________

Name of Ins. Co. ________________ Policy # ________________ Group # ________________

General Insurance Authorization

I certify that I have provided correct insurance coverage information. I authorize the release of any necessary information, including medical information, for this claim or for any related claim, to any insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by an insurance company at any time in writing.

I agree to pay a late charge of two percent (2%) per month on balances unpaid after thirty (30) days from the date of service. I understand that I am responsible for my account. If my account is turned over for collection, I accept responsibility for collection fees, interest, court costs, and attorney fees.

Signature of subscriber or authorized person ________________ **Date** ____/____/____