MINOR PATIENT'S BILLING INFORMATION FORM

(Note: This form will need to be updated each year.)

Patient's
Full Name:_____(_____)
FIRST MIDDLE LAST NAME KNOWN BY

Age:_____ Birthday:_____/_____/_____ Sex: **M F** School:_____
MO DAY YEAR

Address:_____ City:_____ State:_____ Zip:_____

Parent's / Guardian's (Guarantor's) - ***The parent bringing child to the office today.***

Full Name:_____(_____)
FIRST MIDDLE LAST NAME KNOWN BY

Age:_____ Birthday:_____/_____/_____ Sex: **M F** Marital Status: (circle one) **S M D W**
MO DAY YEAR

Social Security #:_____ Driver's License #:_____State:_____

Your home address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

E-Mail address:_____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

Employer:_____ Occupation:_____

Employer's address:_____

City:_____ State:_____ Zip Code:_____

(Please hand our receptionist your driver's license and your health insurance card(s) for us to copy, even if we are out of your network. If you need any tests or surgeries, we will need this information in order to help you schedule outside facilities.)

Other Parent's / Guardian's

Full Name:_____(_____)
FIRST MIDDLE LAST NAME KNOWN BY

Birthday:_____/_____/_____ Social Security #:_____ Telephone(_____)_____
MO DAY YEAR

Home address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

NAME of nearest relative who does NOT live with you:_____

Relationship:_____ Phone Number:(_____)_____

Relative's address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

ASSIGNMENT OF BENEFITS, DISCLOSURE AUTHORIZATION, & PAYMENT ACKNOWLEDGEMENT

I HEREBY authorize any insurance company to pay **Thomas J. Parr, MD, PA** the proceeds of any benefits due me. In case of an excessive delay in processing my insurance claim, I authorize Thomas J. Parr, MD, PA to advise the Texas State Department of Insurance or others (TMA) who could help with insurance collections on my behalf. I further acknowledge that I am responsible for the prompt payment of any charges owed to Thomas J. Parr, MD, PA that are not covered by insurance payments, including payment of interest at the statutory rate prescribed by the State of Texas on all balances unpaid after sixty (60) days. I further authorize my insurance company to obtain any information which may be necessary to determine benefits payable under any insurance policy on which I am covered. A photocopy of this form may be considered as an original for insurance purposes.

Signature:_____Date:_____