

# CARROW STREET PEDIATRICS, PLLC

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## PATIENT INFORMATION

(Please Print)

Patient's Name: \_\_\_\_\_ Male:  Female:   
Phone: (\_\_\_\_) - \_\_\_\_\_ D.O.B: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) - \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

## PRIMARY INSURED INFORMATION

Policyholder's Name: \_\_\_\_\_ Male:  Female:   
Policyholder's Address (if different than patient):  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) - \_\_\_\_\_ D.O.B: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship to Patient: Self:  Spouse:  Child:  Parent:

## SECONDARY INSURANCE

Policyholder's Name: \_\_\_\_\_ Male:  Female:   
Policyholder's Address (if different than patient):  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) - \_\_\_\_\_ D.O.B: \_\_\_\_\_ S.S. #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Relationship to Patient: Self:  Spouse:  Child:  Parent:

## AUTHORIZATION

I hereby authorize Carrow Street Pediatrics, PLLC to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Carrow Street Pediatrics, PLLC. **I certify that the information I have reported with regard to my insurance coverage is correct and I understand that I am responsible for any unpaid charges and will be billed directly.** I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_