OAK TREE PEDIATRICS AND MORE
Child & Family Form
WELCOME AND THANK YOU FOR COMING TO SEE US!

Family Last Name(s)_____**Date**_____

Patient (Name/DOB)_____**(Name/DOB)**_____

Patient (Name/DOB)_____**(Name/DOB)**_____

Patient (Name/DOB)_____**(Name/DOB)**_____

Address_____ **City** _____ **State** _____**Zip** _____

Billing Address _____ **City**_____ **State** _____ **Zip** _____

Preferred Contact Phone #_____**Home#**_____ **Cell#**_____

Email_____ **May we contact you via email? Yes**___ **No**_____

Do any of your children live part time with another person? Yes___ **No**___

If so, please provide us with their contact information on a separate sheet of paper.

****

Mother's Name_____**DOB**_____**SS#**_____

Occupation_____**___ Driver's Lic#**_____

Employed by _____**Work Phone#**_____

Father's Name _____**DOB**_____**SS#**_____

Occupation_____**_____ Driver's Lic#**_____

Employed by _____**Work Phone#**_____ **Cell#**_____

Who may we thank for referring you to our office?_____

Nearest relative NOT living with you _____ **Relationship**_____

Address_____**State**_____**Phone**_____

****

INSURANCE INFORMATION: * <u>Please give card to the receptionist to copy</u> *

Name of Insured (Policy Holder)_____

Name of Primary Insurance Company_____

Member ID #_____ **Group#** _____

Primary Care Physician_____

Do you have other Insurance coverage? Yes___ **No**___ **If so, please provide Ins. Card**

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT COMPLETE BELOW.

Name_____ **Relationship to Patient** _____

Address_____ **City** _____ **State** _____ **Zip** _____

Home #_____**Work #**_____ **Cell #**_____

DOB _____**Driver's#** _____**SS#**_____

Employer_____**Occupation**_____

By the signature below, I hereby certify the correctness of the above information and authorize release of information to my insurance company. I assign benefits to Oak Tree Pediatrics and More, Dr. Spadaro, Dr. Weisz, & Dr. Spinner. A photocopy of the assignment may serve as the original. I hereby agree that in consideration for services rendered by the doctor(s), I shall make prompt payment to my account as bills are presented. If it becomes necessary for the account to be referred to collective action, I shall pay the actual attorney's fees and collection expenses. Interest on uncollected balances shall accrue at 18% Per Annum.

Signed_____**Date**_____

Patient or Responsible Party