PSOP KIDS

PEDIATRIC SPECIALISTS OF PLANO

Date:_____

Patient Information

Last Name:_____First Name:_____Middle Name:_____
Address:_____City:_____State:_____Zip:_____
DOB:_____ SSN:_____-_____-_____ Sex: □ Male □ Female
Sibling:_____DOB:_____Sibling:_____DOB:_____
Sibling:_____DOB:_____Sibling:_____DOB:_____

Primary Guarantor Information & Insurance

Last Name:_____First Name:_____DOB:_____
Address:_____City:_____State:_____Zip:_____
SSN:_____-_____-_____ Sex: □ Male □ Female Relationship to Patient:_____
Employment Status:_____Occupation:_____Employer:_____
Home Phone:_____Work:_____Mobile:_____Email:_____

Insurance Company:_____Subscriber's I.D.#:_____Group#:_____
Insurance Company Address:_____City:_____State:_____Zip:_____
Insurance Company Phone Number:_____

(Please provide your ID card with this information)

Parent/ Guardian Information

Parent/Guardian #1: (if different than Guarantor Information)

Last Name:_____First Name:_____DOB:_____
Address:_____City:_____State:_____Zip:_____
SSN:_____-_____-_____ Sex: □ Male □ Female Relationship to Patient:_____
Home Phone:_____Work:_____Mobile:_____Email:_____
Marital Status:_____Occupation:_____Employer:_____

Parent/Guardian #2: (if different than Guarantor Information)

Last Name:_____First Name:_____DOB:_____
Address:_____City:_____State:_____Zip:_____
SSN:_____-_____-_____ Sex: □ Male □ Female Relationship to Patient:_____
Home Phone:_____Work:_____Mobile:_____Email:_____
Marital Status:_____Occupation:_____Employer:_____

Emergency Contact

Please list someone other than Parent/ Guardian:
Last Name:_____First Name:_____Relationship to Patient:_____
Home Phone:_____Work:_____Mobile:_____Email:_____

Assignment and Release

Please review and sign authorizations below to expedite claim processing. **If you feel that a claim has been denied in error it is your responsibility to contact insurance.** Questions regarding your account may be directed to our billing service, Apple Medical Billing at 800-458-1857.

I hereby authorize payment of medical benefits directly to Pediatric Specialists of Plano. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:_____Date:_____