PEDIATRIC MEDICINE, P.A.

7922 EWING HALSELL DR., SUITE 440
SAN ANTONIO, TEXAS 78229-3726

PLEASE READ CAREFULLY AND PRINT CLEARLY
CHECK, CREDITCARD OR CASH PAYMENT IS REQUIRED FOR EACH VISIT

Patient's Name (Child) _____

__Male __Female Age _____ Date of Birth _____

Father's Name _____ Date of Birth _____

Mother's Name (Maiden) _____ Date of Birth _____

Address _____ Telephone _____

Cell Phone _____

City _____ State _____ Zip Code _____

Father's Employer _____ Occupation _____

Employer's Address _____ Telephone _____

Mother's Employer _____ Occupation _____

Employer's Address _____ Telephone _____

Social Security # (Mother's) _____(Father's) _____Driver' s License # (Mother's)_____(Father's) _____

Emergency Contact Name _____ Telephone _____

INSURANCE INFORMATION

Insured's Name _____ Employer's Name _____

Insurance Company (1) _____

Group Number _____ Policy Number _____

Address to which claims are sent _____

_____

Insured's Name _____ Employer's Name _____

Insurance Company (2) _____

Group Number _____ Policy Number _____

Address to which claims are sent _____

_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Michael A. Ozer, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered valid as the original. I hereby authorize assignee to release all information necessary to secure payment. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

Signed _____ Date_____