Allegheny Podiatry Management, L.L.C.
CHILDREN INSURANCE INFORMATION

THIS PAGE IS TO BE COMPLETED BY THE PARENT/ LEGAL GUARDIAN OR LEGAL CUSTODIAN OF THIS CHILD.

A. THIS PAGE IS TO BE COMPLETED BY THE PARENT/ LEGAL GUARDIAN OR LEGAL CUSTODIAN OF THIS CHILD.

Patient's <Child's> Name: _____ SS#:_____

B. BELOW THIS AREA IS THE PARENT'S INFORMATION ONLY

Mother's Name: _____ SS#: _____
Mother's Date of Birth: _____ Phone #: _____
Address (*if different from patient)*: _____

Employer Name: _____ Phone #: _____
Employer Address: _____

Father's Name: _____ SS#: _____
Father's Date of Birth: _____ Phone #: _____
Address *(if different from patient)*: _____

Employer Name: _____ Phone #: _____
Employer Address: _____

C. BELOW THIS AREA IS THE INSURANCE INFORMATION – If the insurance is under the patient, please complete as needed.

Please PRINT the Name of the Parent/Guardian who Holds this Insurance _____

1. NAME OF INSURANCE: _____ ADDRESS: _____
ID: _____ GROUP#: _____
WHAT IS YOUR RELATIONSHIP TO THE PATIENT?: _____ YOUR DATE OF BIRTH: _____

Is there a 2nd Insurance? PRINT the Name of the Parent/Guardian who Holds this Insurance _____

2. NAME OF INSURANCE:_____ ADDRESS: _____
ID: _____ GROUP#: _____
WHAT IS YOUR RELATIONSHIP TO THE PATIENT?: _____ YOUR DATE OF BIRTH: _____

D. SIGNATURE ON FILE: In order to submit a claim for payment to us for or for reimbursement to you for services covered under your policy, we must have your authorization to release medical information to your insurance carrier. I hereby authorize a physician of Allegheny Podiatry Management, L.L.C., to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by Allegheny Podiatry and DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO ALLEGHENY PODIATRY MANAGEMENT for services I did not pay for.

I understand I am financially responsible to Allegheny Podiatry Management, L.L.C. for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

X _____ Date: _____

Please Print your Name and Relationship to the Patient: _____

IF YOUARE NOT THE PARENT, PLEASE PROVIDE OUR OFFICE WITH YOUR NAME, PHONE NUMBER, ADDRESS AND RELATIONSHIP TO THE PATIENT ON THE BACK OF THIS SHEET. THANK YOU.

Rev. 3/23/10