

CHILD Billing Form

CHILD'S Name: Who referred you?:			<u>Primary Insurance Company Name</u> Address/PO Box City, State, Zip Insurance Phone		<u>Secondary Insurance Company Name</u> Address/PO Box City, State, Zip Insurance Phone	
Date of Birth: _____ Age: _____ Gender: M F			Name of Insured (primary) ID# of Insured Group # : Group Name Date of Birth of Insured		Name of Insured (secondary) ID# of Insured Group # : Group Name Date of Birth of Insured	
Home Address: City, State, Zip: E-Mail: Your Employer: Your Occupation:			Your Relation to Insured Person Self ____ Spouse ____ Partner ____ Child ____ Parent ____		Your Relation to Insured Person Self ____ Spouse ____ Partner ____ Child ____ Parent ____	
Home Phone: _____ May we call ? Yes <input type="checkbox"/> No <input type="checkbox"/> Leave a message ? Yes <input type="checkbox"/> No <input type="checkbox"/> Work Phone: _____ May we call ? Yes <input type="checkbox"/> No <input type="checkbox"/> Leave a message ? Yes <input type="checkbox"/> No <input type="checkbox"/> Cell Phone: _____ May we call ? Yes <input type="checkbox"/> No <input type="checkbox"/> Leave a message ? Yes <input type="checkbox"/> No <input type="checkbox"/>			Street Address City, State, Zip Phone		(If Different) Street Address City, State, Zip Phone	
Spouse or Partner Name		Birth Date	Spouse Employer			
Name of Others in Home		Birth Date	Relation			

- I authorize the release of any health information necessary to process insurance claims for services provided by Dr Conner. This release of information expires December 31, 2010.
- I authorize my insurance company to pay medical benefits to the provider of services, Dr Conner. I request payment of government benefits either to myself or to the party who accepts assignment.
- I understand that I am fully responsible for all professional fees not covered by this assignment.
- I understand that payment in full is due at the time of service unless prohibited by Dr Conner's contract with my insurer.

Signature _____ **Date** _____