

WEST CHESTER PEDIATRICS, INC.

Arthur J. Moebius, MD and Shahin F. Shareef, MD

7665 Monarch Ct, Suite 104/105, West Chester, Ohio 45069

Phone (513) 779-4006 Fax (513) 779-7018

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____
D.O.B.: ____ / ____ / ____ SEX: _____

INSURANCE INFORMATION

PRIMARY: POLICY HOLDER'S NAME: _____

POLICY HOLDER'S BIRTH DATE: _____ POLICY HOLDER'S SEX: MALE / FEMALE

INSURANCE CARRIER: _____ POLICY HOLDER'S SSN: ____ / ____ / ____

POLICY ID #: _____ GROUP #: _____

SECONDARY: POLICY HOLDER'S NAME: _____

POLICY HOLDER'S BIRTH DATE: _____ POLICY HOLDER'S SEX: MALE / FEMALE

INSURANCE CARRIER: _____ POLICY HOLDER'S SSN: ____ / ____ / ____

POLICY ID #: _____ GROUP #: _____

PATIENT MAILING ADDRESS:

ADDRESS _____ APT. # _____ CITY _____ STATE _____ ZIP _____

PRIMARY PHONE # (_____) _____

WHO LIVES AT THIS HOUSEHOLD: _____
(PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S SOCIAL HISTORY)

PARENT /

GUARDIAN 1: NAME _____ DATE OF BIRTH ____ / ____ / ____

LIVES WITH PATIENT? YES / NO RELATION TO PATIENT _____
(PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S FAMILY MEDICAL HISTORY)

IF **NO**, PLEASE LIST CONTACT'S PRIMARY PHONE NUMBER: _____ IS THIS A CELL PHONE? YES / NO

AND THEIR ADDRESS _____

WORK PHONE # _____ CELL PHONE # _____

SOCIAL SECURITY # ____ - ____ - ____ OCCUPATION _____ PLACE OF EMPLOYMENT _____

PARENT /

GUARDIAN 2: NAME _____ DATE OF BIRTH ____ / ____ / ____

LIVES WITH PATIENT? YES / NO RELATION TO PATIENT _____
(PLEASE NOTE, THIS INFORMATION IS BEING REQUESTED TO IMPROVE INTAKE OF YOUR CHILD'S FAMILY MEDICAL HISTORY)

IF **NO**, PLEASE LIST CONTACT'S PRIMARY PHONE NUMBER: _____ IS THIS A CELL PHONE? YES / NO

AND THEIR ADDRESS _____

WORK PHONE # _____ CELL PHONE # _____

SOCIAL SECURITY # ____ - ____ - ____ OCCUPATION _____ PLACE OF EMPLOYMENT _____

EMERGENCY CONTACT (OTHER THAN PARENTS)

NAME _____ RELATIONSHIP _____

PHONE # _____

ADDITIONAL CONTACT QUESTIONS

WHO SHOULD RECEIVE BILLING STATEMENTS? _____

IS THE ADDRESS THE SAME AS THE PATIENT? YES / NO

IF NO, PLEASE SUPPLY THE ADDRESS:

IF PARENTS ARE DIVORCED OR SEPARATED, PLEASE FILL OUT THIS SECTION:

WHO HAS CUSTODY? _____

ARE THERE ANY LEGAL RESTRICTIONS THAT WOULD RESTRICT THE NON-CUSTODIAL PARENT FROM CONSENTING TO MEDICAL TREATMENT FOR THE CHILD OR FROM OBTAINING INFORMATION ABOUT THE CHILD'S MEDICAL TREATMENT: YES / NO

IF YES, PLEASE EXPLAIN AND PROVIDE A COPY OF ANY LEGAL PAPERWORK THAT SUPPORTS THIS RESTRICTION:

PLEASE READ CAREFULLY: The following statement cannot be edited or altered in any way.

By my signature, I authorize West Chester Pediatrics, Inc. (WCP) to examine and provide medical treatment. I authorize WCP to release any medical or incidental information that may be necessary for either medical care or in the processing applications for financial benefit. I authorize my insurance company to issue payment directly to WCP. I assume full responsibility for any balance due after my insurance benefit has been processed and will remit it immediately upon receipt of a billing statement. I understand that 1) It is my responsibility to know all rules and restrictions of my insurance policy, to know which hospitals, emergency rooms, lab facilities, radiology departments, specialists which are assigned to me according to my insurance policy rule. 2) Copay and/or co-insurance is due at time of service. 3) It is my responsibility to supply WCP with the correct insurance information as well as any changes to my mailing address and telephone numbers. 4) Any costs WCP incurs as a result of debt recovery on my account will be passed along to me. 5) It is WCP's policy to disclose Protected Health Information in accordance with HIPPA Privacy and Security standards for Treatment, Payment and Health care operations.

X _____ / /
SIGNATURE OF PARENT OR GUARDIAN RELATIONSHIP DATE