

SAMUEL R. WILLIAMS, M.D., P.A.

PATIENT INFORMATION

Name of Minor/Child _____
Last Name First Name

Sex M F Birthdate _____ SS # _____

Home Address _____
Street

City _____ State _____ Zip _____ Telephone _____

Child Lives with Mother Father Both Other

Whom may we thank for referring you? _____

Siblings Names	Birthdate
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PARENT INFORMATION

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
Cell Phone _____	Cell Phone _____
Employer _____	Employer _____
Soc. Sec. # _____ Birthdate _____	Soc. Sec. # _____ Birthdate _____
Father's Occupation _____	Mother's Occupation _____

Parents are: (circle) Single Married Separated Divorced Widowed

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? (other than parents)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary Insurance: _____

Complete Mailing Address: _____
Phone # _____

Policy Holder's Name: _____ Relationship _____

Policy # _____ Group # _____

Secondary Insurance: _____

Complete Mailing Address: _____
Phone # _____

Policy Holder's Name: _____ Relationship _____

Policy # _____ Group # _____

RELEASE AND ASSIGNMENT

Person(s) financially responsible _____

AUTHORIZATION TO Samuel R. Williams, M.D./PA

I hereby authorize payment of any medical insurance benefits for which I am entitled to be made directly to the above provider. I agree to pay the balance of any charges not paid or covered under my insurance plan. I also authorize release of medical information necessary to process any and all claims to Samuel R. Williams, M.D./PA and their billing agent.

Signature of Parent/Guardian

Date