

## FAMILY AND INSURANCE INFORMATION

Please complete the following form to aid us in updating your clinical records. All information is strictly confidential.

Father/Guardian's Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Relation \_\_\_\_\_  
Address \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
Employer \_\_\_\_\_ Maiden Name \_\_\_\_\_

Children/Patients (Full Name)	DOB	Sex	SS#
1 _____			
2 _____			
3 _____			
4 _____			

Child lives with:      Both Parents      Mother      Father      Other \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
Relationship \_\_\_\_\_

**INSURANCE (Please present insurance card so copy may be obtained)**

Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_  
Address of Company \_\_\_\_\_ Group# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Effective Date \_\_\_/\_\_\_/\_\_\_  
Subscriber's Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Relation \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_  
Medicaid# (if applicable) \_\_\_\_\_

It is the member's responsibility to obtain referrals for specialty care in advance of services being rendered if the insurance is a managed care plan. I understand that I am responsible for services not authorized by my PCP. I hereby authorize payment directly to the provider of services and I understand that I am financially responsible for charges not covered by this authorization. I hereby authorize the release of any medical information necessary to process my insurance.

\*\*\*\*\*  
It is the policy of this office that the person who accompanies the child for care will be responsible for payment of services rendered. Individuals other than parents/guardians bringing children to the office will be expected to present payment and/or insurance information. Payment required at the time of service-unless prior arrangements have been made.  
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I UNDERSTAND AND GIVE AUTHORIZATION TO ALL ABOVE STATEMENTS.

Signed \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

I HAVE BEEN GIVEN A NOTICE OF PRIVACY PRACTICES OF NASSIM & ASSOCIATES, PSC.

Signed \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

