Patient Profile18 Years & Older

Please review and make any necessary changes to the information on this profile form

Patient Information:

Patient's Name: ____________________ ID #:______ Sex: [ ]M [ ]F DOB: __________ SSN# ____________Race: ____________

Address: ____________________ ____________________City:____________________ State: ______ Zip: __________

Phone # ____________________ [ ]Home [ ]Work [ ]Cell

Email Address: ______________________________ Employer: ______________________________

Parent/Guardian Contact Information:

Name: ______________________________ Phone # ______________________________

Address: ______________________________ DOB: ______________________________

City/State/Zip: ______________________________ Social Security # ______________________________

Primary Insurance Information:

Insured Party: ____________________

Insured Phone: ____________________

Insured Social Security #: ____________________

Insured Date of Birth: ____________________

Patient Relationship to Insurance Holder: __________

Insurance Holder

Company: ______________________________

Insured ID: ______________________________

Policy Group: ______________________________

Copay/Coinsurance ______________________________

Other Contacts:

Name: ____________________ Phone: ______________ Relationship: ____________________

Name: ____________________ Phone: ______________ Relationship: ____________________

*** Insurance coverage is a contract between you and your insurance company. It is your responsibility to know what your plan does and does not cover.**

*** We will file insurance claims for you, but you are responsible for amounts not paid by insurance. I also understand that all co-payments, deductibles and co-insurances are due at the time of service.**

*** I authorize payment of medical benefits to be made directly to Pediatric & Adolescent Associates, PSC for services performed. I further agree to be fully responsible for all lawful debts incurred for services provided.**

*** We will only file secondary insurance for those who have Medicaid, WellCare or Coventry Cares of Kentucky as their secondary insurance. You are responsible for filing all other secondary insurance.**

*** I consent to be contacted by regular mail, email or by telephone (including a cell phone number) regarding any matter related to my account with Pediatric & Adolescent Associates, PSC.**

______________________________ ______________________________

Signature of Patient **Date**