ASSOCIATES IN FAMILY PRACTICE
12210 Plum Orchard Drive, Suite 212
Silver Spring, Maryland 20904
301-622-6020

PLEASE PRINT CLEARLY

MINOR PATIENT'S NAME:____
FIRST MIDDLE LAST

STREET ADDRESS:____

CITY,STATE,ZIP:____

GENDER: MALE FEMALE (CIRCLE ONE) DATE OF BIRTH:______________________
SSN:______________________ HOME PHONE:______________________

MOTHER'S NAME:____
ADDRESS:____
HOME PHONE:______________________ WORK/CELL PHONE:______________________
CELL PHONE:______________________ DATE OF BIRTH:______________________
EMPLOYER:______________________ OCUPATION:______________________

FATHER'S NAME:____
ADDRESS:____
HOME PHONE:______________________ WORK/CELL PHONE:______________________
CELL PHONE:______________________ DATE OF BIRTH:______________________
EMPLOYER:______________________ OCUPATION:______________________

IS THE PATIENT ALLERGIC TO ANY MEDICATION?: YES NO (CIRCLE ONE)
MEDICATION NAME:____

INSURANCE INFORMATION

PRIMARY INSURANCE:______________________ POLICY HOLDER:______________________
ID NUMBER:______________________ GROUP NUMBER:______________________
POLICY HOLDER SSN:______________________ POLICY HOLDER DOB:______________________
POLICY HOLDER EMPLOYER:____

SECONDARY INSURANCE:______________________ POLICY HOLDER:______________________
ID NUMBER:______________________ GROUP NUMBER:______________________
POLICY HOLDER SSN:______________________ POLICY HOLDER DOB:______________________
POLICY HOLDER EMPLOYER:____

AUTHORIZATION

I, ______________________, hereby authorize Associates in Family Practice, P.A. (AIFP) to apply for benefits on my behalf for services rendered to my minor child and request that payment be made by my insurance company and that my payments be sent directly to AIFP. I understand that it is the policy of AIFP to only bill my insurance company if they participate with that company, and if they do not, it will be my responsibility to submit the claim to my insurance company for reimbursement of my expenses. I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is past due, it will be turned over to collections. I understand am responsible for reasonable attorney's fees and cost of collection in the event of default. I understand am responsible for reasonable attorney's fees and cost of collection in the event of default. Further, I understand that there is a $35.00 fee for returned checks.

I certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim or benefits, in order to process any claim for benefits.
Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this at any time in writing.

SIGNATURE OF PATIENT:______________________________ DATE:______________________