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_____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone_____

Cell Phone_____

Employer _____

Soc. Sec. #_____ Birthdate_____

Father's Occupation_____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone_____

Cell Phone_____

Employer _____

Soc. Sec. #_____ Birthdate_____

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