RAINBOW PEDIATRICS

PATIENT INFORMATION

Today's Date / /

PATIENT DEMOGRAPHICS

First Name	MI	Last Name
Date of Birth / /	Gender (circle one) M F	Social Security Number - -
Home Phone ( ) -	Alternative Phone ( ) -	
Mailing Address 1		
Mailing Address 2		
City	State	ZIP Code

Mother's First Name	MI	Last Name
Date of Birth / /	Social Security Number - -	
Father's First Name	MI	Last Name
Date of Birth / /	Social Security Number - -	

PARTY RESPONSIBLE FOR PATIENT

First Name	MI	Last Name
Relationship (circle one) Mother Father Legal Guardian Other :		
Marital Status (circle one) Single Married Divorced Widowed Legally Separated		
Mailing Address 1		
Mailing Address 2		
City	State	ZIP Code

Please continue on next page.

RAINBOW PEDIATRICS

CONTACT INFORMATION

Today's Date / /

EMERGENCY CONTACT

First Name	MI	Last Name
Relationship (circle one) Parent Relative Legal Guardian Friend Other :		
Home Phone ( ) -	Alternative Phone ( ) -	
Mailing Address 1		
Mailing Address 2		
City	State	ZIP Code

PARTIES ALLOWED TO BRING PATIENT TO APPOINTMENTS

Person #1's First Name	MI	Last Name
Relationship (circle one) Parent Relative Legal Guardian Friend Other :		
Person #2's First Name	MI	Last Name
Relationship (circle one) Parent Relative Legal Guardian Friend Other :		
Person #3's First Name	MI	Last Name
Relationship (circle one) Parent Relative Legal Guardian Friend Other :		
Person #4's First Name	MI	Last Name
Relationship (circle one) Parent Relative Legal Guardian Friend Other :		

If any other person not listed brings patient, we will need consent from a parent of legal guardian. People bringing in a patient **MUST** carry an I.D. to show at the front desk. This is to ensure your child's safety.

Thank you!

Please continue on next page.

RAINBOW PEDIATRICS

INSURANCE INFORMATION

Today's Date / /

PRIMARY INSURANCE INFORMATION

Company Name		
Policy Number	Group Number	
Is the patient the policy holder? (circle one) Yes (if "Yes" skip to Secondary Insurance) No (if "No" please fill out the information below)		
First Name	MI	Last Name
Date of Birth / /	Gender (circle one) M F	Social Security Number - -
Patient's Relationship to Policy Holder (circle one) Child Step-Child Foster Child Other:		
Home Phone ( ) -	Alternative Phone ( ) -	
Policy Holder's Mailing Address 1 (if different from Patient)		
Mailing Address 2		
City	State	ZIP Code
Employer	Employer's Phone ( ) -	

SECONDARY INSURANCE INFORMATION

Company Name		
Policy Number	Group Number	
Is the patient the policy holder? (circle one) Yes (if "Yes" skip to Page 4) No (if "No" please fill out the information below)		
First Name	MI	Last Name
Date of Birth / /	Gender (circle one) M F	Social Security Number - -
Patient's Relationship to Policy Holder (circle one) Child Step-Child Foster Child Other:		
Home Phone ( ) -	Alternative Phone ( ) -	
Policy Holder's Mailing Address 1 (if different from Patient)		
Mailing Address 2		
City	State	ZIP Code
Employer	Employer's Phone ( ) -	

Please continue on next page.

RAINBOW PEDIATRICS

AUTHORIZATION

Today's Date / /

AUTHORIZATION

I authorize Dr. Ahmed Rezk to release medical information or to give a copy of medical records to the following people:

Person #1's Name	Phone ( ) -
Person #2's Name	Phone ( ) -

Parent or Legal Guardian's Signature

Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of any information relating to all claims or benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance to pay Dr. Ahmed Rezk all benefits, if any, otherwise payable to me for services as described on the attached forms. I further acknowledge that any insurance benefits received by Dr. Ahmed Rezk will be credited to my account in accordance with the above said agreement.

I understand that I am financially responsible for all charges incurred.

Parent or Legal Guardian's Signature

Date

THANK YOU FOR CHOOSING RAINBOW PEDIATRICS!

Who can we thank for the referral? Referred by

The biggest compliment you can pay us is by referring us to your family and friends!