230 Fountain Court, Suite 260
Lexington, KY 40509
859-264-0660 Voice
859-264-0662 Fax
www.actpeds.com

Patient Information:

Name: ______________________ Sex: M F

Date of Birth: ______________ Social Security: ______________

Address: ______________________

____

Home Phone: ______________ Cell Phone: ______________

Guardian Information:

Mother: ______________ Home Phone: ______________

Address: ______________________

____

Work Phone: ______________ Cell Phone: ______________

Father: ______________ Home Phone: ______________

Address: ______________________

____

Work Phone: ______________ Cell Phone: ______________

Insurance Information:

Insurance Carrier: ______________ Policy Holder: ______________

Policy Holder DOB: ______________ Social Security #: ______________

Person Responsible for Account: ______________________

I authorize the release of any medical information necessary to process insurance claims filed on my behalf.
I authorize payment of medical benefits to be made directly to A Caring Touch Pediatrics and their physicians.

______________________ Parent / Guardian

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