# *Welcome To Our Practice!*

## Child's Information

Today's Date________________

Male / Female

Last Name________________________ First Name__________________ DOB________

Address________________________________________ Landline________________

________________________________________ Mother's Cell____________

________________________________________ Father's Cell____________

City State Zip

Mother's email__________________________ Father's email__________________________

Hospital of Birth ____________________________________________________________

Siblings & DOB's ____________________________________________________________

Emergency Contact ________________________________________ Phone ____________

Who should we thank for referring you to our practice?

____________________________________________________________________

Person Responsible for Account (Insurance Holder)

Last Name______________________________ First Name____________________

Relationship to patient __________________________ DOB__________________

Address________________________________________

________________________________________

________________________________________

City State Zip

Insurance Company__________________________

Subscriber ID____________________________ Group #______________________

Other Parent's Information

Last Name______________________________ First Name____________________

Relationship to patient __________________________ DOB__________________

Address________________________________________

________________________________________

________________________________________

City State Zip

**Assignment and Release**

I hereby authorize payment directly to Alena Ashenberg, MD for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________________________________________________________

**Signature of Responsible Party** **Date**