PREMIER ORTHOPAEDIC & HAND CENTER S.C.

MINOR INSURANCE INFORMATION FORM

PATIENT:_____

FATHER_____d.o.b.____/____/_____

Address if different from patient:_____

Social Security Number_____

MOTHER_____d.o.b.___/____/_____

Address if different from patient:_____

Social Security Number_____

INSURANCE:

PRIMARY: Name of Company_____

Who is insured party? Dad_____Mom_____Other_____
If not Dad or Mom..Name_____d.o.b.____/____/_____
Relation to Patient_____Social Security _____

Group #_____ID_____

SECONDARY: Name of Company_____

Who is insured party? Dad_____Mom_____Other_____
If not Dad or Mom..Name_____d.o.b.___/___/_____
Relation to Patient_____Social Security_____

Group #_____ID_____

I authorize Southland Bone & Joint Institute, S.C. to release information regarding services rendered and allow a photocopy of my signature to be used to file insurance. I authorize and direct my insurer to issue payment for services directly to Southland Bone & Joint Institute, S.C. Regardless of my insurance benefits, if any, I understand that I am responsible for fees and services rendered. In the event of non-payment, I understand that I am responsible for collection, attorney and court costs.

Father's Signature_____Date_____

Mother's Signature_____Date_____