MARY ANN ELLIS-JAMMAL, M.D., F.A.A.P.
PEDIATRICS

Patient Information

Name _____

Address _____

City _____ State ____ Zip_____

Phone(s) _____

Date of Birth _____ Age _____ Sex _____

Insurance Information

Primary Insurance _____
ID Number _____
Phone Number _____

Secondary Insurance _____
ID Number _____
Phone Number _____

Insured's Employer

Employer Address _____

City _____ State ____ Zip_____

Phone Number _____

Siblings to Patient

_____

_____

Parent/Guarantor/Responsible Party

Name _____

Address _____

City _____ State ____ Zip_____

Phone(s) _____

Date of Birth _____

Patient's Parent/Guardian

Name _____

Relationship to Patient _____

Address _____

City _____ State ____ Zip_____

Phone(s) _____

Emergency/Alternate Contact

Name _____

Relationship to Patient _____

Address _____

City _____ State ____ Zip_____

Phone(s) _____

RELEASE OF INFORMATION

I hereby authorize Mary Ann Ellis-Jammal, M.D. to furnish and disclose all known facts concerning my care to my insurance company and other physicians upon my request.

DATE _____ **SIGNATURE** _____

ASSIGNMENT OF BENEFITS

I hereby authorize (name of insurance) _____to make payment directly to Mary Ann Ellis-Jammal, M.D. of any insurance benefits otherwise payable to me for his professional services rendered to date and not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company or for any charges not paid within 90days of billing to said insurance company. A copy of this authorization shall be valid as the original.

DATE _____ **SIGNATURE** _____