Pediatric Orthopaedic Associates of Silicon Valley

Jeffrey S. Kanel, MD

PATIENT INFORMATION FORM

This form must be filled out completely or we cannot bill your insurance.

Patient Name:_____, _____ **MI**_____
(Last) (First)

Sex: M F Birthdate:_____/_____/_____ Age:_____
(month) (day) (year)

Referred by_____ Regular doctor if different _____

Father's Name: _____, _____
(Last) (First)

Birthdate: _____/_____/_____ Social Security # _____
(month) (day) (year) (needed for billing insurance)

Address _____ City _____ State _____ Zip_____

Home Phone: (_____)_____ Cell Phone (_____)_____

Employer:_____ Work Phone (_____)_____

Mother's Name: _____, _____
(Last) (First)

Birthdate: _____/_____/_____ Social Security # _____
(month) (day) (year) (needed for billing insurance)

Address _____ City _____ State _____ Zip_____

Home Phone: (_____)_____ Cell Phone (_____)_____

Employer:_____ Work Phone (_____)_____

Marital status of patient's parents: married single divorced widowed (please circle one)

Person responsible for ins.: _____, _____
(Last) (First)

Birthdate: _____/_____/_____ Social Security # _____
(month) (day) (year) (needed for billing insurance)

Address _____ City _____ State _____ Zip_____

Home Phone: (_____)_____ Cell Phone (_____)_____

Employer:_____ Work Phone (_____)_____

To whom should statements be sent?_____

Name of Insurance Company:_____

Policy # _____ Group #_____

Ins. Plan: PPO POS EPO MC HMO If HMO, name of Medical Group:_____

I hereby authorize Jeffrey S. Kanel to furnish any designated insurance company all information necessary to file a health insurance claim. I hereby authorize payment of surgical and/or medical benefits to Pediatric Orthopaedic Associates of Silicon Valley for medical services as directed on the attached. I also understand I am financially responsible for all charges whether or not paid by my insurance company. **All appointments must be cancelled at least 24 hours in advance. Failure to do so will require a $35 fee. Please inform the receptionist if you have any insurance, address, or phone changes. There will be a $35 fee to re-bill your insurance.**

Signed_____ **Date**_____