PATIENT INFORMATION UP DATE

(This form must be fully completed).

This information is used solely for the purpose of verifying and obtaining the correct Insurance Information so that we can continue to file with your insurance carrier. It is company policy that insurance information must be up dated every six months.

Please note that it is very **IMPORTANT** that at any time there is a change in your insurance information as well personal information it is your responsibility to advise the front desk staff of these changes. These changes will avoid in delays in payment.

Name(s) of child/children	Date of Birth
1._____	_____
2._____	_____
3._____	_____
4._____	_____

Primary Insured Name: _____

Date of Birth: _____

Social Security #: _____

Current home address: _____

Current telephone #: _____ Current work #: _____

Current Employer: _____

Medical Insurance Company: _____ Effective date: _____

ID #: _____ Group #: _____

Medical Insurance Company telephone #: _____

*I hearby agree to assign insurance benefits for the about listed children for medical services rendered, to **COPPELL PEDIATRIC ASSOCIATES, P.A**. I, agree to pay for services when not covered by insurance benefits. I hereby authorize **COPPELL PEDIATRIC ASSOCIATES, P.A**. to release any information necessary to the insurance company to receive payment of benefits.*

_____ _____

Parent/Guardian Signature Date

Please return this form along with your insurance card and driver's license to the front desk for each child so that we may copy them for your file.

FOR OFFICE USE ONLY

Insurance card copied _ Staff initials: _____

Driver's license copied _ Staff initials: _____

Computer up dated: _ Staff initials: _____

Patient chart up dated: _ _ _ _ _ Staff initials: _____

Date scanned: _____ Staff initials: _____ Date completed: _____