UT Le Bonheur
Pediatric Specialists

GERALD R. JERKINS, M.D.

Date _____

Primary Care Physician _____ Address _____

Phone ( ) _____

Referring Physician _____ Address _____

Phone ( ) _____

Patient's Name _____ Date of Birth _____ Sex _____ Race _____

Drug Allergies _____ Patient's SS # _____

Responsible Party's Name _____ S.S. # _____ D.O.B. _____

Address _____ Phone ( ) _____
(Street) (City) (State) (Zip)

EMERGENCY CONTACT **(NOT PARENTS)** NAME AND PHONE _____

Father's Name _____ S.S. # _____ D.O.B. _____
(Last) (First)

Home Address _____ Home Phone ( ) _____
(Street) (City) (State) (Zip)

Cell Phone ( ) _____

Employment _____ Address _____ Work Phone ( ) _____

Mother's Name _____ S.S. # _____ D.O.B. _____
(Last) (First)

Home Address _____ Home Phone ( ) _____
(Street) (City) (State) (Zip)

Cell Phone ( ) _____

Employment _____ Address _____ Work Phone ( ) _____

WE APPRECIATE PAYMENT AT THE TIME OF SERVICE
WE ARE UNABLE TO FILE YOUR INSURANCE WITHOUT A COPY OF YOUR CARD

Primary Insurance Co. _____

Insured's Name _____

Address for Claims _____

Insured's S.S. # _____

Subscriber & Group # _____

Phone _____

Secondary Insurance _____

Insured's Name _____

Address for Claims _____

Insured's S.S. # _____

Subscriber & Group # _____

Phone _____

AUTHORIZATION

I hereby authorize Gerald R. Jerkins, M.D., to furnish information carriers concerning this treatment and I hereby irrevocably assign to the doctors all insurance benefits otherwise payable to me but not to exceed the charges shown. I understand that I am financially responsible for all charges not covered by this authorization. I also understand that I am responsible for collection fees of this account.

Our Policy is payment at time of service. Billing fees will be assessed after 45 days.

Signed _____ Relationship to Patient _____