|  |  |
| --- | --- |
| Today’s Date: Requesting Site: | Rendering Provider: |

### PATIENT INFORMATION

|  |  |
| --- | --- |
| Child’s Name: (first/last) | Parent/Guardian: |
| Phone Number:  | DOB: Gender: M or F |
| Street Address: | City/State/Zip: |
| Diagnosis: | Services Requested: | Diagnosing Physician: |
| Date of Diagnosis: | Diagnosing Physician Contact: |
| Primary Care Physician: | Primary Care Physician Contact: |

### INSURANCE INFORMATION

**Primary insurance: \_\_New Insurance \_\_ Old Insurance \_\_Termed Date \_\_ /\_\_/\_\_**

|  |  |
| --- | --- |
| Subscriber’s name: |  Birth date: |
| Subscriber’s S.S. no.: | Policy no: | Group No: |
| Subscriber’s Address: |  |
| Employer: |
| Patient’s relationship to subscriber:  |

**Secondary insurance:**

|  |  |
| --- | --- |
| Subscriber’s name: |  Birth date: |
| Subscriber’s S.S. no.: | Policy no: | Group No: |
| Subscriber’s Address: |  |
| Employer:  |  |
| Patient’s relationship to subscriber:  |

**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD**

|  |  |
| --- | --- |
| Financially Responsible Name: | Phone Number: |
| Address: |  |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Circle City ABA** or insurance company to release any information required to process my claims

|  |  |
| --- | --- |
| Patient/Guardian signature | Date |