Praful U Bhatt M.D.
72 E. Church St.
Lock Haven, PA 17745
(570) 748-4565

WELCOME!!

About Your Child

Child's Name: ___________________
Child's Birth date: __/__/__ Boy [ ] Girl [ ]
Child's Soc Sec # _____-_____-_____
Child's Home Address: ________________
____
____
Child's Home Phone # (___) ____________
School/ Daycare Name: ________________
Pharmacy Name:______________________
Pharmacy Telephone# (___) ____________
Referred by: __________________________

Who is Accompanying This Child Today

Name: _____________________________
Relationship: ________________________
Are you the legal guardian of the child? ___

Family Information

Parents Marital Status:
[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Mother's Name: _____________________
[ ] Biological [ ] Step Mother [ ] Guardian
Mother's Current Physical Health is:
[ ] Good [ ] Fair [ ] Poor
Mother's Blood Type is ____ and RH is ___
Birth date ___/___/___ SS # ____________
Home Address: ______________________
____
Home Phone: __________ Cell # ________
Employer: __________ Work Phone ______
Email ______________ D.L. #___________

Family Information

Father's Name: ______________________
[ ] Biological [ ] Step Father [ ] Guardian
Father's Current Physical Health is:
[ ] Good [ ] Fair [ ] Poor
Father's Blood Type is ____ and RH is ____
Birth date ___/___/___ SS # ____________
Home Address: _______________________
____
Home Phone: _________ Cell # _________
Employer: __________ Work Phone _____
Email _____________ D.L. #___________

Who is Responsible for Making Appointments?
[ ] Mother [ ] Father [ ] Other (Below)
Name: ______________________________
Address: ____________________________
Home Phone __________ Cell # _________
Employer: _________ Work Phone _______

Please List Any Other Children:

Name____________ DOB ____________
Boy [ ] Girl [ ]
Name____________ DOB ____________
Boy [ ] Girl [ ]
Name____________ DOB ____________
Boy [ ] Girl [ ]

In the Event of an Emergency, Who Should We Contact, other than the Child's Parents?
Name: _____________________________
Relationship: ________________________
Cell Phone # ________________________
Work Phone # _______________________
Home Phone # _______________________

Insurance Information

Primary Insurance Company

Ins. Co. Name: ______________________

Address: ____________________________

____

Phone # ____________________________

Subscriber's Name: ___________________

Subscriber's ID # _____________________

Group # ____________________________

Relationship: ________________________

DOB __________ Subscriber's SS# ________

Subscriber's Employer _________________

Employer's Address ___________________

Business Phone # _____________________

Insurance Information

Secondary Insurance Company

Ins. Co. Name: ______________________

Address: ____________________________

____

Phone # ____________________________

Subscriber's Name: ___________________

Subscriber's ID # _____________________

Group # ____________________________

Relationship: ________________________

DOB __________ Subscriber's SS# ________

Subscriber's Employer _________________

Employer's Address ___________________

Business Phone # _____________________

Credit Card Authorization

Credit Card and Card # ____________________

Credit Card Exp Date _____________________

Name as it appears on card ________________

Address of Card Holder ____________________

____

(i) I understand that the practice will bill me first. I would have an option to pay the balance with my personal check or using my credit card information on file at the office.

(ii) If I fail to send payment within 30 days, I authorize Dr. Bhatt's office to automatically charge the balance on my credit card.

I hereby authorize Dr. Praful U. Bhatt to charge the balance owed for our child/children, after insurance payment, to my credit card. I understand that a copy of the charge will be mailed to me at the above address. I allow a copy of my credit card to be kept in the file and the information will be kept confidential by the practice.

Signature of Card Holder: _________________

Account Information

Person Ultimately Responsible for Account

Name: ____________________________________ Relationship: ____________________________________

Billing Address: ____

Home Phone # ____________________________________ Employer: ____________________________________

Work Phone # _______________________________ SS # _________________________ D.L. # _________________________

Our Policy Requires Assignment and Release

Our office policy requires payment in full for all medical services rendered at the time of the visit. **The person bringing the patient to this office is responsible for the charges unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expense (cost paid to collection agency or legal fees and billing charges) incurred in collecting this account.**

I hereby authorize payment directly to Praful U. Bhatt, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance and for all services on my behalf or my dependents.
I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand the above information, guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my insurance coverage. I have read the financial policy of the practice and agree to abide by it.

Signature: ____ Date: ____________________________________