MARY ANN ELLIS-JAMMAL, M.D., F.A.A.P.
PEDIATRICS

Patient Information

Name____________________________________

Address__________________________________

City_______________ State____Zip___________

Phone(s) ___________________________________

Date of Birth ____________ Age _____ Sex _____

Race ______ Ethnicity _______ Language _______

Insurance Information

Primary Insurance __________________________

ID Number ________________________________

Group Name & Number______________________

Subscriber Name_____________________________

Subscriber Date of Birth______________________

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(**Tricare Insured Only)Active Duty: YES or NO**

Type_____ _______________________________

S.S. OR Benefit #___________________________

Sponsor Name_______________________________

Sponsor Date of Birth_________________________

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Insured's Employer

Employer Name ___________________________

Address__________________________________

City ___________________ State ____ Zip______

Phone ____________________________________

Patient's Parent/Guardian
Guarantor/Responsible Party for Billing

Name____________________________________

Address__________________________________

City ___________________ State ____ Zip_____

Phone(s) _________________________________

Relationship to Patient______________________

Date of Birth ______________________________

Email ____________________________________

Patient's Parent/Guardian

Name ____________________________________

Address __________________________________

City __________________ State ____ Zip______

Phone(s) _________________________________

Relationship to Patient______________________

Date of Birth______________________________

Emergency/Alternate Contact

Name ____________________________________

Relationship to Patient ______________________

Address ___________________________________

City ___________________ State ____ Zip______

Phone(s) __________________________________

Siblings to Patient (name & date of birth)

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RELEASE OF INFORMATION

I hereby authorize Mary Ann Ellis-Jammal, M.D. to furnish and disclose all known facts concerning my care to my insurance company other physicians , or persons / facilities upon my request.

DATE __________________________ SIGNATURE ____

ASSIGNMENT OF BENEFITS

I hereby authorize (name of insurance) _______________________________to make payment directly to Mary Ann Ellis-Jammal, M.D. of any insurance benefits otherwise payable to me for his professional services rendered to date and not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company or for any charges not paid within 90 days of billing to said insurance company. A copy of this authorization shall be valid as the original.

DATE ___________________________ SIGNATURE ____