

GREGORY J. MACKAY, M.D., P.C.
DONALD R. NUNN, M.D.
M. SUSANN BEDFORD, M.D

DATE OF OFFICE VISIT: _____

CHILD'S SEX : MALE / FEMALE

LAST AS APPEARS ON INS. CARD

FIRST AS APPEARS ON INS. CARD

MIDDLE

NICKNAME

BIRTHDATE

____-____-____
SSN

ADDRESS

CITY, STATE, ZIP

HOME PHONE

REASON FOR VISIT

PATIENT'S ALLERGIES

REFERRED BY

PEDIATRICIAN

EMERGENCY CONTACT

RELATIONSHIP TO PATIENT

PHONE NUMBER

FATHER'S NAME:

SSN#:

DATE OF BIRTH:

PHONE:

CELL:

EMPLOYER:

MOTHER'S NAME:

SSN#:

DATE OF BIRTH:

PHONE:

CELL:

EMPLOYER:

MARITAL STATUS OF PARENTS: SINGLE/MARRIED/DIVORCED/SEPERATED/WIDOW

INSURANCE COMPANY:

INSURED'S NAME:

POLICY#:

I HEREBY AUTHORIZE GREGORY J. MACKAY, M.D. TO BILL MY INSURANCE CARRIER FOR ANY SERVICES RENDERED BY HIM OR ANY AGENTS OF HIS PRACTICE. WITH THIS AUTHORIZATION I ASSIGN ANY AND ALL BENEFITS PAYABLE FOR SERVICES RENDERED BY GREGORY J. MACKAY, M.D. OR AGENTS OF HIS PRACTICE TO GREGORY J. MACKAY, M.D. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE PLAN. I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION NECESSARY TO THE TREATMENT I RECEIVE WHILE UNDER THE CARE OF GREGORY J. MACKAY, M.D. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION, INCLUDING X-RAYS, PATHOLOGY, LABORATORY AND OPERATIVE REPORTS TO GREGORY J. MACKAY, M.D. A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

GUARDIAN'S SIGNATURE

DATE