the children's clinic
Special care for special people

SAM J. DENNEY, JR., M.D., F.A.A.P.
GORDON H. MEADOR, M.D., F.A.A.P.
SAMUEL A. SMITH, M.D., F.A.A.P.
AMANDA COOK, M.D., F.A.A.P.
LAURA A. BARRON, M.D., F.A.A.P.
M. ADAM ADCOCK M.D., F.A.A.P.

P.O. BOX 321434 • FLOWOOD, MISSISSIPPI 39232 • (601) 420-8233 • FAX (601) 936-5370

Patient Update:

Child's Full Name: _____
(PLEASE ADD ALL CHILDRENS' NAMES ABOVE)
Social Security #: _____
DOB: _____Female: _____ Male:_____
Primary Pharmacy: _____
Pharmacy City: _____
Pharmacy Phone #: _____

Race
□ African American or Black
□ American Indian/Alaska Native
□ Asian
□ Caucasian/White
□ Native Hawaiian or Pacific Islander
□ Multi-Racial or Other
□ Unknown □ Declined

Ethnicity
□ Hispanic □ Not Hispanic
□ Declined □ Unknown

Responsible Party: □ Mother □ Father

Billing Address: _____
City, State, Zip: _____
Primary Phone #: _____ Alt. #: _____Work #: _____
(circle preferred contact number)
Primary Insurance Co.: _____
Policy Holder: _____ DOB: _____
SS#: _____ Relation to Pt. _____ Ins. Eff. Date: _____
Insurance ID# _____ Group # _____
Deductible: $ _____ Co pay for OV $ _____

Assignment of Benefits

I hereby authorize payment directly to The Children's Clinic, PLLC for all insurance benefits otherwise payable to me for services rendered. I certify that the information I have reported to The Children's Clinic, PLLC with regard to my insurance is correct. I also authorize the release of any necessary information, including medical information, if requested by my insurance company. I permit a copy of this authorization to be used in such instances. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents.

Responsible Party or Patient (if over the age of 18): _____ **Date**: _____