Tracy Hoos, DO
Jennifer Denton, APRN

Hoos Pediatrics
904 W Okmulgee
Muskogee 74401
918-910-7991

PATIENT INFORMATION (PLEASE PRINT & Fill Out Completely)

Date: ___________________________

Patient's Name: First _______________________ Middle_________________________ Last ______________________

Preferred Name: ___________________ Date of Birth: ____________ Age : ___________ Sex: M or F

Patient's Address: ____

City, State & Zip: ____

Preferred Provider (please circle one): Dr. Hoos Jennifer Denton Preferred Pharmacy: ________________________

Parent or Person Responsible for Bill (person under which insurance is carried):

____

Relationship to Patient: ____________________ **Date of Birth** _____________ EMAIL: _________________________

Address: ____ Home Phone: (_____) ___________

City: _______________________________________ State: ______ Zip: _____________ Mobile Phone: (_____) _________

Marital Status of Parents: ❑Married ❑Divorced ❑Separated ❑Other:______________________________

IF NOT MARRIED, Who Has Custodial Rights: ❑ Mother ONLY ❑Father ONLY ❑Both Parents ❑Other________

Father's Name____________________________________ DOB: _____________SS #___________________

Cell Phone: (_____) ________________ Work Phone: (_____) ______________

Father's Address: ____

Name of Employer: ____

Mother's Name____________________________________ DOB: _____________ SS#_________________________

Cell Phone: (_____) ______________ Work Phone: (_____) ________________

Mother's Address: ____

Name of Employer: ____

Emergency Contact (Not living with you):

Name & Relationship: ____Phone: (_____)___________

INSURANCE INFORMATION

Name of Insured: ____

Name of Insurance Company: ____ Phone (_____)_______

I.D. Number: ____ Group Number: ___________

I certify that I will be financially responsible for all medical expenses for the above patient in the event they should lose coverage of Medicaid during the course of treatment. **Sign:** ____

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PLEASE READ: Payment is required ***in full*** at the time of each visit. The patient, their parent, or their guardian are responsible for all fees, regardless of Insurance coverage. We will file insurance only as a courtesy, but ultimately our patients are responsible for all outstanding balances regardless of coverage.

AUTHORIZATION:

I understand that I will be charged (not my insurance) for canceled appointments unless I give 24 hours' notice.
All of the office policies have been provided to me and I understand all policies. I agree to all policies that have been provided to me in writing.

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process insurance claims.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize and request payment of medical benefits directly to Hoos Pediatrics

I CERTIFY THAT I AM THE RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE TO and SIGN ON BEHALF OF THE PATIENT FOR ALL SERVICES RENDERED. I, ALSO, CERTIFY THAT I AM THE FINACIALLY RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE and THAT I HAVE THE AUTHORITY TO AGREE TO ALL PRACTICE POLICIES AND FINANCIAL POLICIES.

Printed Name ____ **Relationship** ________________________________

Signature____ **Date**_____________________________