

***Pediatric Orthopaedic Associates of Silicon Valley***

**Jeffrey S. Kanel, MD**

**PATIENT INFORMATION FORM**

**This form must be filled out completely or we cannot bill your insurance.**

**Patient Name:** \_\_\_\_\_, \_\_\_\_\_ **MI** \_\_\_\_\_  
(Last) (First)

Sex: M F Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_  
(month) (day) (year)

Referred by \_\_\_\_\_ Regular doctor if different \_\_\_\_\_

**Father's Name:** \_\_\_\_\_, \_\_\_\_\_  
(Last) (First)

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security # \_\_\_\_\_  
(month) (day) (year) (needed for billing insurance)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_, \_\_\_\_\_  
(Last) (First)

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security # \_\_\_\_\_  
(month) (day) (year) (needed for billing insurance)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Marital status of patient's parents: married single divorced widowed (please circle one)

**Person responsible for ins.:** \_\_\_\_\_, \_\_\_\_\_  
(Last) (First)

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security # \_\_\_\_\_  
(month) (day) (year) (needed for billing insurance)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

To whom should statements be sent? \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Plan: PPO POS EPO MC HMO If HMO, name of Medical Group: \_\_\_\_\_

I hereby authorize Jeffrey S. Kanel to furnish any designated insurance company all information necessary to file a health insurance claim. I hereby authorize payment of surgical and/or medical benefits to Pediatric Orthopaedic Associates of Silicon Valley for medical services as directed on the attached. I also understand I am financially responsible for all charges whether or not paid by my insurance company. **All appointments must be cancelled at least 24 hours in advance. Failure to do so will require a \$35 fee. Please inform the receptionist if you have any insurance, address, or phone changes. There will be a \$35 fee to re-bill your insurance.**

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_