THE KIDSMD

Douglas Marira, MD, MA, MPH
304 Stephenson Avenue
Savannah, GA 31405
Phone: 912.692.1181 | Fax: 912.692.1184
Pediatrician Board Certified by the
American Board of Disability Analysts

DATE

WELCOME TO OUR OFFICE!
PATIENT INFORMATION

Patient Name: _____
LAST FIRST MI NICKNAME

Address: _____ Home Phone: _____

Address: _____ Work Phone: _____
CITY STATE ZIP CODE

_____ _____ _____ _____ _____
SEX (M/F) EMPLOYED (Y/N) MARITAL STATUS SOCIAL SECURITY # DATE OF BIRTH

Referring Doctor: _____

Emergency Contact: _____ Phone Number: _____

If patient is not the primary cardholder, please provide cardholder SS# and Date of Birth with employer information.

Employer: _____
NAME OCCUPATION

Employer Address: _____ Work Phone: _____
CITY STATE ZIP CODE

Spouse Name: _____ Spouse Employer: _____

Copies of all insurance cards required before services are rendered.
If patient is a dependent or minor please complete the following information:

Legal Guardian & SSN: _____ Relationship to Patient: _____

Address: _____ Work Phone: _____
CITY STATE ZIP CODE

The undersigned hereby grants to THE KIDS MD authorization for reasonable and proper treatments and procedure by today's standards that are deemed necessary for the patient named here.

I give permission for this office to release needed information for insurance and quality review purposes. A photocopy of this authorization may be used for insurance purposes. I authorize payment directly to the above named entity of the insurance benefits herein specified and otherwise payable to me. I understand that I am responsible for charges not covered by this assignment. This assignment and release of any medical information in all respects is applicable for my physician, as well as any physician's assistant and or family nurse practitioner who may be involved in my care.

I also understand that such treatment and procedures will be performed by employees of THE KIDS MD and physicians, and also that, unless otherwise requested, medical, nursing, and other personnel in training and their instructors may be present at and participate in such treatment and procedures.

Signature of Patient or Guardian: _____

I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.

Signature of Patient or Guardian: _____