# ALBERT G. KARAM, M.D., P.A. | REBECCA PRENGLER, M.D.

## PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Date: _____ Referred By: _____ Race: _____ Sex: _____

Other family members who are patients: _____

Preferred Pharmacy: _____ Pharmacy Address: _____ City: _____

## RESPONSIBLE PARTY INFORMATION

Father's Name: _____ DOB: _____ SS#: _____

Address: _____ Home#: _____

Street City State Zip Code Cell#: (dad) _____

Mother's Name: _____ DOB: _____ SS#: _____

Address: _____ Home#: _____

Street City State Zip Code Cell#: (mom) _____

Father's Employer: _____ Position: _____

Address: _____ Work#: _____

Mother's Employer: _____ Position: _____

Address: _____ Work#: _____

Emergency Contact: _____ Phone#: _____

## INSURANCE SUBSCRIBER INFORMATION

Name of Insured: _____ DOB: _____ SS#: _____

## AUTHORIZATIONS

**TO RELEASE INFORMATION:** I authorize Albert G. Karam, M.D., P.A., or Daniel D. Nale, M.D., P.A., or their covering Physicians, their designee or assigns (collectively referred to as "Physician") to release and furnish all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physician or to facilitate the collection or review of data for purposes of utilization review, quality assurance or medical outcomes, evaluation or other evaluation. Such information may be released to insurance companies, managed care organizations, third party administrators or their affiliates or Independent Practice Associations or Management Service Organizations or their affiliates to which Physician may become a member or any organization contracting with any of the above entities to perform such functions.

**FOR TREATMENT:** I authorize and give my consent to Physician to treat my child as he deems medically necessary in the event of my absence.

**FOR PAYMENT: If I am a member of a health care plan, I understand that I must present my Health Plan Identification at each visit or I agree to pay the charges billed Physician at the time of the visit. I understand that I am responsible for all co-payments and deductibles under the plan and must pay them at the time of the visit.**

In the event I request that Physician provide medical services, lab procedures or immunizations which are not authorized, covered or deemed medically necessary by my health care plan, I hereby agree, in advance, to pay Physician at his customary billed charges for such services. In the event that my physician does not perform certain in-office lab services under my health plan, And I request that physician perform such lab services in his office for my convenience, I agree to pay Physician at his billed charges since this service is considered to be "out of network." I authorize payment of Medical benefits to Physician or supplier designated on claim.

My signature below indicates I have read and understand the authorizations above.

Child Name: _____ Date: _____

Signature of Parent or Legal Guardian: _____