Date: _____

List ALL Child/Children :

Last Name	First	MI	Sex	DOB	Race (See above) (White/Asian/Black/ African American/Hawaiian/Pacific Isander)	Ethnicity (Hispanic/Latino) (Non Hispanic/Latino)

Address: _____

City: _____ State: _____ Zip: _____

Home # (____) _____ Cell # (____) _____

Email Address: _____

Father's Name: _____ SS# _____ Birth Date: _____

Father's Employer: _____ Work #/Cell (____) _____

Mother's Name: _____ SS# _____ Birth Date: _____

Mother's Employer _____ Work #/Cell (____) _____

Language spoken at home _____

I authorize the release of any payment and medical information necessary to process this claim and related claims.

Signed: _____

I authorize payment of medical benefits to undersigned physician or supplier for services described.

Signed: _____