☐ **Thomas B. Dawson M.D.** ☐ **Jaime E. Ramirez, M.D.**

*** FEE POLICY:** *To help control costs, we ask our patients to pay for their office visits or insurance required co-payments / co-insurance payments at the time services are rendered.*

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Father's (Guardian's) Name _____ D.O.B.____/____/____

Mother's (Guardian's) Name _____ D.O.B.____/____/____

Street _____City_____State_____Zip_____

Home Phone _____ Father's Work _____ Mother's Work_____

Father's Cell _____ Mother's Cell _____

****

Name of Children & Dates of Birth:_____

_____

Referred to this Office By:

_____

****

Father's Employer _____ Social Security # _____

Occupation _____ Driver's License #_____

Employer's Address _____

Mother's Employer _____ Social Security # _____

Occupation _____ Driver's License #_____

Employer's Address _____

****

Insurance Company _____ Co-Pay $ or Co-Insurance %_____

Primary Holder of Insurance_____

Person Responsible for this Bill _____

****

IN CASE OF EMERGENCY (When parents are not available)

Nearest Relative's Name_____

Relationship to Patients _____

Address

_____ Home

Phone _____Work Phone _____

****

Authorization:

The undersigned patient or individual acting on behalf of the patient, understands and agrees as follows:

1. Drs. Dawson and Ramirez are granted permission to release to my insurance carriers, or referring physicians, any information in connection with any treatments rendered to patient..

2.. Patient shall pay this office those amounts which are due for services rendered. In the event that the patient's insurance company, if there be any that this office files, does not make payment or only a partial payment, this obligation shall be the responsibility of the patient..

3. Patient authorizes payment of medical benefits to this office for services rendered.

Signature _____ Date _____