PRIMARY PHYSICIAN: Dr. Spewak ____ Dr. O'Neil ____ Dr. Whiteside ____ Dr. AuBuchon ____ Dr. Menolascino ____

Who referred you to our office? _____ Number of Children with our office: _____

PATIENT INFORMATION: *(Please list each child's full name)* Today's Date: _____

1. _____ Date of birth _____ Sex M F
2. _____ Date of birth _____ Sex M F
3. _____ Date of birth _____ Sex M F
4. _____ Date of birth _____ Sex M F

Address: _____ Phone: ( ) _____

City: _____ State: _____ Zip: _____

❑ Mother ❑ Father ❑ Guardian

Name: _____

SS#: _____

Birth Date: _____

Place of employment: _____

Cell #: _____ Wk.#: _____

❑ Mother ❑ Father ❑ Guardian

Name: _____

SS#: _____

Birth Date: _____

Place of employment: _____

Cell #: _____ Wk. #: _____

Marital Status of Parents: Single Married Divorced Separated

E-mail Address: _____

In the case of an emergency please provide the name and number of someone not living at your address:

Name: _____ Address: _____

City: _____ State: ____ Zip: _____ Phone ( ) _____

CONSENT: ***I give my consent for the following person(s) to bring my child(ren) for medical treatment.***

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

INSURANCE INFORMATION:

Parent or guardian responsible for child(ren): _____

NOTE: ***The majority of insurance carriers use "birthday rule" (whichever parent's birthday is first in the Calendar year) to decide primary coverage for the child.***

Primary Insurance Co.

Insurance Co.: _____

Insured Parent: _____

ID Number: _____/Group #: _____

Effective Date: _____

Secondary Insurance Co.

Insurance Co.: _____

Insured Parent: _____

ID Number: _____/Group #: _____

Effective Date: _____

If Insured Parent different than Mother/Father's names listed at top, please provide:

Insured Parent's Name: _____

SS#: _____ Date of Birth: _____

Relationship to Patient: _____

Place of Employment: _____

Phone #: Home: _____ Work: _____

FINANCIAL RESPONSIBILITY: **Payment/co-payment is expected at the time of visit regardless of who presents this child(ren) for treatment. I hereby authorize Southwest Pediatrics, Inc. to furnish my insurance company all the information which said insurance company may request concerning treatment for above named patient(s). I hereby assign to Southwest Pediatrics the medical benefits to which my dependent(s) is entitled under my insurance plan. I understand that I am responsible for the charges incurred. In the event that I fail to pay these charges, I will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account.**

MEDICAL RELEASE OF INFORMATION: **I hereby give consent to release copies of the above-named child(ren)'s medical records (including records containing behavioral and psychiatric information) to my past and present insurance companies for claims processing, their quality improvement programs, their accreditation, and any other purposes for which they may request records. I understand that by authorizing release of these records to my past and present insurance companies, I am releasing Southwest Pediatrics, Inc. and my physician(s) listed above from liability for utilization of these copies by the insurance company.**

Signed: _____ ***Date*** _____

Parent/Legal Guardian