Southwest Pediatrics

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Today's date____________

Patient Information ______Male ______Female

Patient Name____
Last First Middle

Patient Address____
Street Apt # City State Zip

Date of Birth______________________ Patient Social Security #____________________

Phone #__________________________ E-Mail Address____________________

Referred By____

Other family members seen in our office______________________________

Emergency contact____
Name/Relationship Address Phone#

Parent Information

Mother's Name____
Last First Middle

Mother's Address____
Street Apt # City State Zip

Mother's Employer____
Company Address Phone #

Mother's and Father's Cell Phone______________________________
Mothers Fathers

Father's Name____
Last First Middle

Father's Address____
Street Apt # City State Zip

Father's Employer____
Company Address Phone #

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Company____________________	Secondary Company____________________
Identification #____________________	Identification#____________________
Subscribers Name____________________	Subscribers Name____________________
Subscribers SSN____________________	Subscribers SSN____________________
Subscribers Date of Birth____________________	Subscribers Date of Birth____________________

Authorization

I authorize the release of any medical or any other information necessary to process this claim. I also authorize payment of medical benefits to the physician or supplier for services rendered. I am financially responsible to all non-covered services and deductibles. This authorization will remain in effect for the duration of my association with this practice.

Signature (patient or parent/guardian) ______________________________________