SOUTHERN HILLS PEDIATRICS

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Board Certified in Pediatrics

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Patient Name:

Last. *First Int.*

NEW PATIENT REGISTRATION

PATIENT HISTORY INFORMATION Date _____ 20 _____

Please do not leave any spaces blank!!

Name of Child (Patient) _____ Date of Birth _____ M ____ F ____
First M.I. Last

Child's School(s) _____ Siblings Name _____ DOB _____ M ____ F ____
Siblings Name _____ DOB _____ M ____ F ____
FORM MUST BE COMPLETED Siblings Name _____ DOB _____ M ____ F ____

Father's Full Name

Mother's Full Name

Father's Social Security Number Date of Birth

Mother's Social Security Number Date of Birth

Father's Employer (if "self" give details)

Mother's Employer (if "self" give details)

Employer's Address Phone

Employer's Address Phone

Legally Married ____ Single ____ Divorced ____ Widowed ____

Did you have a prenatal Consultation 'Yes' or 'No'

Home Address _____ Phone Number _____
City State Zip

E-mail Address _____ Cell Number _____

Father's Insurance Company _____ Ins. ID # _____
Grp. # _____

Father's Ins. Company Address _____ Effective Date of Coverage _____

Dependant Coverage YES _____ NO _____

Mother's Insurance Company _____ Ins. ID # _____
Grp. # _____

Mother's Ins. Company Address _____ Effective Date of Coverage _____

Dependant Coverage YES _____ NO _____

Nearest Friend _____
Name & Address Phone

Nearest Relative _____
(Not at same address) Name & Address Phone

How did you hear about us? Phonebook _____ Magazine_____ Neighbor_____ Other Physicians_____ Other_____

**Please initial next to the following statements in which you agree.

1)_____ I authorize Southern Hills Pediatrics to provide any emergency care for my child(ren) including hospitalization, if necessary, in my absence.

2)_____ I authorize _____ (or any responsible party or guardian at the time of the visit) to bring my child(ren) to Southern Hills Pediatrics for routine medical care.

3)_____ I understand that failure of my insurance company to pay any portion of charges Southern Hills Pediatrics, for my child(ren), will result in these charges becoming MY responsibility (including collection fees).

4)_____ I authorize the release of medical records to any specialist that my child may be referred to if requested.

5)_____ I authorize Southern Hills Pediatrics, to confirm my child(ren's) appointments prior to an office visit.

6)_____ I authorize the release of any medical information necessary to process my claims.

7)_____ I authorize payment of government benefits to Southern Hills Pediatrics.

8)_____ I authorize payment of medical benefits to undersigned physician or facility for services my child will receive.

Signature (Parent/Guardian) Date

* This form is legal document. Your signature states the information you provided is true, correct and understood. Any questions or concern you have may be address to Southern Hills Pediatrics office staff during your visit.