Southwest Pediatrics

Patient Registration

Patient Information

Name (First) _____ (M.I.) ____ (Last) _____

Street Address _____

City _____ State ____ Zip _____

Date of Birth _____ Age _____ Gender ☐ Male ☐ Female

Who referred you to us? _____

Parent Information #1

Name _____ Date of Birth _____

Relationship ☐ Mother ☐ Father ☐ Foster parent ☐ Other guardian _____

Home phone _____ Cell phone _____ Work phone _____

Employer _____ Occupation _____

Social Security Number _____

Parent Information #2

Name _____ Date of Birth _____

Relationship ☐ Mother ☐ Father ☐ Foster parent ☐ Other guardian _____

Home phone _____ Cell phone _____ Work phone _____

Employer _____ Occupation _____

Social Security Number _____

Insurance Information

Name of insurance company _____ Effective date _____

Subscriber's name _____

Group number _____ Policy number _____

Emergency Contact (Other than above)

Name _____

Relationship _____ Phone _____

Co-pays are due at the time of service. Parent/guarantor is responsible for all charges incurred. I authorize payment of benefits directly to my physician.

I understand that if I have a total of three (3) no show appointments within one year and I fail a fourth appointment, my family will be dismissed from Southwest Pediatrics.

Parent or Guardian signature _____ Date _____