South Dayton Pediatrics, Inc.

Patient Information: **Date:_____**

LAST NAME	FIRST NAME	MI	SEX M ○ F ○	DATE OF BIRTH	SS #

STREET ADDRESS/ P.O. BOX	CITY	STATE	ZIP

HOME PHONE	MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? YES ○ NO ○ MAY WE CONTACY YOU ON YOUR CELL PHONE? YES ○ NO ○

Father's/Guardian #1's Information:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SS #

STREET ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMPLOYER NAME/WORK PHONE #

Mother's/Guardian #2's Information:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SS #

STREET ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMPLOYER NAME/WORK PHONE #

Insurance/Policy Holder Information: (Please Present Insurance Card(s) To Receptionist)

PRIMARY INSURANCE	POLICY HOLDER	SEX M ○ F ○	POLICY HOLDER DOB	POLICY HOLDER SS #

EMPLOYER	WORK PHONE	POLICY HOLDER RELATIONSHIP TO PATIENT PARENT STEPPRENT GRANDPARENT OTHER_____

Secondary Insurance:

PRIMARY INSURANCE	POLICY HOLDER	SEX M ○ F ○	POLICY HOLDER DOB	POLICY HOLDER SS #

EMPLOYER	WORK PHONE	POLICY HOLDER RELATIONSHIP TO PATIENT PARENT STEPPRENT GRANDPARENT OTHER_____

Next Of Kin/Emergency Contact: (Must Be Someone Other Than Either Parent/Guardian)

NAME	RELATIONSHIP TO PATIENT	PHONE #
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I have received and reviewed a copy of "Notice of Privacy Practices" as required by law.

I authorize South Dayton Pediatrics, Inc. to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to South Dayton Pediatrics, Inc. (or to the party that accepts the assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I authorize the physician and assistants to examine and treat.

This authorization may be revoked either by me or by my insurance company at any time in writing.

I assume full financial responsibility for any charges denied by my insurance carrier.

_____ _____

Signature of Responsible Party Date

Who else has permission to authorize treatment* for your child: (Please include name and relationship to the patient):

_____

_____

***This is someone other than a parent (who has automatic authorization) in the instance either parent is unable to bring the child to an appointment.**

Please provide your email (_____)
to receive a link to our online patient portal through FollwMyHealth. You will follow the directions in the email you receive to create an account for your child/ren and gain free access to their medical records. You can also use this portal to send your requests for prescription refills and ask non-emergent questions (we do ask up to 24 hours for responses and refills). If the patient has any lab work done, the results will show on the patient portal once your doctor has reviewed them.