Southwest Pediatric Associates Patient Registration

Please Print

Mother's Name: ___________________________________ Mother's Date of Birth: ______________________
Last and First
Mother's Social Security Number: ________________________ Mother's employer: _____________________

Mother's Occupation: ______________________ Employer's Phone #:________________________________

Father's Name: ___________________________________ Father's Date of Birth: ________________________
Last and First
Father's Social Security Number: ________________________ Father's employer:_______________________

Father's Occupation: ______________________ Employer's Phone #:_________________________________

Address of Parents or Custodian: ____
Is this your mailing address? ☐ yes ☐ no OTHER____

Home Ph: ( ) ________________ Cell Ph: ( ) ________________ Email address: ____________________

Name of Custodian: ____ (If child is not living with Parent)

Emergency Contact: ____ Ph: ______________________
Name Relationship

Name of Insurance Company: ______________________________ Primary Ins. Holder: Mom☐ Dad☐ Self☐

Ins. ID #:______________________________ Group#:________________

Claims Address: ____
PO BOX, City and State
Please place secondary here as well

Please list all children in the family: (Even those not being seen today)

____ Male ☐ Female ☐
Last Name, First Name, Middle Name and Date of Birth

____ Male ☐ Female ☐
Last Name, First Name, Middle Name and Date of Birth

____ Male ☐ Female ☐
Last Name, First Name, Middle Name and Date of Birth

____ Male ☐ Female ☐
Last Name, First Name, Middle Name and Date of Birth

I hereby authorize payment of insurance benefits directly to Southwest Pediatrics. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted provider of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred. I authorize the performance of whatever procedures necessary in executing the treatment of the above named patient(s).

_________________________________ _______________________
Signature of Parent/Guardian Date