South Tulsa Pediatrics - Patient Information Form for Patients Over 18 Years of Age

PATIENT'S NAME _____ DOB _____ M / F

Cell Phone _____ Home Phone _____

Email _____

PREFERRED MEANS OF CONTACT: O TEXT MESSAGE O PHONE CALL O HOME PHONE

Address_____ APT _____

City/State/Zip _____

Employer _____ Work Phone _____

Social Security Number _____

ETHNICITY

O HISPANIC OR LATINO O NOT HISPANIC OR LATINO
O UNKNOWN O DECLINE TO SPECIFY

RACE(S)

O ASIAN O HAWAIIAN NATIVE or PACIFIC ISLANDER
O BLACK O AMERICAN INDIAN or ALASKAN NATIVE
O WHITE O DECLINE TO SPECIFY

LANGUAGE(S)

O ENGLISH
O SPANISH
O OTHER _____

DO WE HAVE PERMISSION TO RELEASE PERSONAL HEALTH INFORMATION TO YOUR PARENT(S) OR GUARDIAN? _____ YES _____ NO

Authorization above will remain in effect until rescinded in writing; or until _____

PRIMARY INSURANCE

INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ DOB _____

MEMBER ID# _____ GROUP # _ _____

EMPLOYER _____

EFFECTIVE DATE _____ OFFICE VISIT COPAY _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT O SELF O PARENT O STEP-PARENT O LEGAL GUARDIAN

DID YOU PROVIDE THE OFFICE WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD? ☐ YES

PHARMACY PREFERENCE _____ LOCATION,CITY _____

PHARMACY PHONE _____

PLEASE COMPLETE AND SIGN ON THE SECOND PAGE

BUSINESS OFFICE USE: UPDATED BY _____ DATE _____

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Father's Name _____ Cell Phone _____

Address _____ Home Phone _____

City/State/Zip _____

Employer/Occupation _____ Work Phone _____

Mother's Name _____ Cell Phone _____

Address _____ Home Phone _____

City/State/Zip _____

Employer/Occupation _____ Work Phone _____

EMERGENCY CONTACT PREFERENCE

Name: _____ Phone: _____ Relationship: _____

WHO SHOULD WE CONTACT FOR BILLING AND INSURANCE QUESTIONS?

_____

- In the event all or any portion of the balance due becomes past due, the patient listed above accept responsibility for the full amount past due.
- Payment made by check or credit card is subject to a service fee of $20.00 per item in the event the check or credit card is returned as a stop payment item.
- I (we) have read and agree to abide by the financial policies of South Tulsa Pediatrics, PLLC.
- I hereby authorize the release of any medical or other information necessary to process claims for services provided by this practice. I also authorize payment directly to my physician's benefits otherwise payable to me but not to exceed my indebtedness to said physician. I understand I am financially responsible to the physician for charges not covered by this agreement. A copy of this assignment is as valid as the original.

PATIENT'S SIGNATURE DATE

PRINT NAME RELATIONSHIP TO PATIENT

BUSINESS OFFICE USE: UPDATED BY _____ DATE _____