South Tulsa Pediatrics - Patient Information Form
PLEASE FULLY COMPLETE ALL 3 PAGES

PATIENT'S FULL NAME — BIRTH DATE

FIRST CHILD _____ _____ **MALE** O **FEMALE** O

SECOND CHILD _____ _____ **MALE** O **FEMALE** O

THIRD CHILD _____ _____ **MALE** O **FEMALE** O

FOURTH CHILD _____ _____ **MALE** O **FEMALE** O

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 _____

ARE PARENTS: O Married O Single O Divorced O Separated O Widowed

PATIENT IS LIVING WITH: O Both Parents O Father O Mother O Parent and Step-Parent O Other _____

PRIMARY CONTACT

O BIOLOGICAL MOM O STEP-MOM O ADOPTIVE MOM O FOSTER MOM O LEGAL GUARDIAN (FEMALE)
O BIOLOGICAL DAD O STEP-DAD O ADOPTIVE DAD O FOSTER DAD O LEGAL GUARDIAN (MALE)
O OTHER _____

Name: _____ SSN: _____
Address: _____ Birth date:_____
City:_____
State: _____ Zip Code: _____ Cell Phone: _____
Employer/Occupation: _____ Home Phone: _____
Email: _____ Work Phone: _____

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

SECONDARY CONTACT

O BIOLOGICAL MOM O STEP-MOM O ADOPTIVE MOM O FOSTER MOM O LEGAL GUARDIAN (FEMALE)
O BIOLOGICAL DAD O STEP-DAD O ADOPTIVE DAD O FOSTER DAD O LEGAL GUARDIAN (MALE)
O OTHER _____

Name: _____ SSN: _____
Address: _____ Birth date:_____
City:_____
State: _____ Zip Code: _____ Cell Phone: _____
Employer/Occupation: _____ Home Phone: _____
Email: _____ Work Phone: _____

EMERGENCY CONTACT (not a parent)

Name: _____ Phone: _____ Relationship: _____

BUSINESS OFFICE USE: UPDATED BY _____ DATE _____

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NEW INSURANCE OR CHANGE OF POLICY INFORMATION

THIS FORM MUST BE UPDATED ANNUALLY OR WHEN THERE IS A CHANGE OF INSURANCE IN ORDER TO MAINTAIN A VALID AUTHORIZATION TO FILE YOUR INSURANCE. **A COPY OF YOUR INSURANCE CARD(S) MUST BE ATTACHED TO THIS FORM.**

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

SECONDARY INSURANCE (if applicable)

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

DOES YOUR CHILD HAVE INSURANCE COVERAGE THROUGH SOONERCARE?

_____NO _____YES

PLEASE COMPLETE AND SIGN ON THE NEXT PAGE

BUSINESS OFFICE USE: UPDATED BY _____ DATE _____

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The parent or responsible party who accompanies the patient to each visit is responsible for co-payments, co-insurance, and deductibles for that visit. South Tulsa Pediatrics, PLLC, will not become involved in payment issues that arise and will expect that parents/guardian will take care of their financial obligations for their child's

PERSON(S) RESPONSIBLE FOR THE BILL: _____

IF PARENTS ARE DIVORCED, WHICH PARENT HAS PHYSICAL CUSTODY? (if applicable) _____

I have read and agree to abide by the financial policies of South Tulsa Pediatrics, PLLC.
I hereby give authorization to the physicians and staff of South Tulsa Pediatrics, PLLC to treat my child(ren) with reasonable and proper medical care by today's standards (including immunizations).
I understand copies of the Financial Policy (including no show policy and collection policy) and Notice of Privacy Practices are available in the office and on our website. I understand copies are available upon request. I understand that I am bound by the terms of the policies and failure to do so could result in dismissal.
I understand both biological parents have access to full disclosure of their child's medical information (even if they are not the custodial parent) and can authorize someone to bring their child to their appointments in their absence.
I understand the patient portal is in place for my benefit and if misused my access can be terminated by the practice.
I understand, in the interest of building a trusting relationship with our adolescents and teenagers, the providers may not be able to discuss all teenage issues discussed at appointments with the parents, unless the physician feels the patient is a danger to themselves or has been abused. This confidential information will also not be accessible on the portal.
I authorize South Tulsa Pediatrics, upon my request, to fax any forms or immunizations records to my child's school.
I understand that South Tulsa Pediatrics may provide immunization information to the Oklahoma State Immunization Information System.
I understand that I am personally responsible for being aware of dates and times of my scheduled appointments.
I understand that I am responsible for all charges whether or not covered by insurance and that all copayments are due at the time of service.
I agree to keep laboratory testing and referral appointments as ordered by the doctors.
I understand the office requires 48 hours notice for prescription refill requests.
I understand if there are custody orders in place I must present current copies for my child's file. If custody issues interfere with our physicians providing proper medical care you may be asked to find a facility that better suits your needs.
I authorize South Tulsa Pediatrics to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners.
I authorize my insurance plan to make direct payment of medical benefits to South Tulsa Pediatrics.

PARENT OR GUARDIAN SIGNATURE DATE

PRINT NAME RELATIONSHIP TO PATIENT

BUSINESS OFFICE USE: UPDATED BY _____ DATE _____