Welcome To Our Practice

PATIENT INFORMATION FORM

Date _____

NORTHWEST PEDIATRICS

Eve Switzer, MD
Tiffanie Anderson, APRN
Angela Johnston, PA
Allison Payne, MD

PATIENT INFORMATION

First name _____ Middle _____ Last _____
Birth date _____
Address _____
City _____ State _____ Zip Code _____
Gender ☐ M ☐ F SS# _____
Race ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other Race
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

PHONE NUMBERS

Mother's Cell Phone _____ Other Ph. _____
Father's Cell Phone _____ Other Ph. _____

IN CASE OF EMERGENCY, CONTACT (adult not living with child)

Name _____
Relationship _____
Cell Ph. _____ Other Ph. _____

PARENT/GUARDIAN INFORMATION

First name (mother) _____ Last _____
Maiden _____
Date of Birth _____
Home _____
City _____ State _____ Zip _____
E-mail _____

First name (father) _____ Last _____
Date of Birth _____
Home _____
City _____ State _____ Zip _____
E-mail _____

PRIMARY INSURANCE INFORMATION

Subscriber name _____ Birth date _____
Relationship to patient _____ SS# _____
Insurance company _____
Address _____
ID or group # _____ Second ID or group# _____

SECONDARY INSURANCE INFORMATION

Subscriber name _____ Birth date _____
Relationship to patient _____ SS# _____
Insurance company _____
Address _____
ID or group # _____ Second ID or group# _____

FINANCIAL AGREEMENT: I certify that the above information is correct to the best of my knowledge. The undersigned hereby authorizes the release of any and all information of documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature on each claim submitted for myself and/or dependents. I hereby authorize my insurance company to pay and hereby assign directly to Enid Clinic Inc dba Northwest Pediatrics. I further acknowledge that any insurance benefits, when received and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility in accordance with our contractual agreements with your insurance and when governed by state/federal law. Full payment is due at the time of services unless other arrangements have been made. I understand that I have the primary duty and obligation to pay my doctor for his/her services, notwithstanding any contract I may have with any third party payer (i.e. insurance company, employer, etc.) I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. There is a $35.00 service charge on all returned checks.

HIPAA DISCLOSURE: Enid Clinic Inc dba Northwest Pediatrics shall not publish or otherwise make generally available any protected individually identifiable health information of data that identifies a patient for purposes other than treatment, payment or other health care operations without his/her express written consent. This does not restrict the internal use of such information or data that is required in the performance of the scope of work that this office has been engaged to perform for our patients. This office maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. As our patient, you have the right to request special privacy protections. You have the right to request restrictions on certain uses and disclosure of your health information, by written request specifying what information you want to limit and what limitation on our use or disclosure of that information you wish to have imposed. I hereby acknowledge that this medical practices' Notice of Privacy has been made available to me.

I request the following restrictions to the use and/or disclosure of my health information: _____

I authorize Northwest Pediatrics to render any medical care necessary to my child if I am not available and no other legal guardian is available. ☐ Yes ☐ No

Signature of Patient or Responsible Party	If person signing is not patient, please state relationship	Date
X		

Welcome To Our Practice

PATIENT INFORMATION FORM

Date _____

NORTHWEST PEDIATRICS

Eve Switzer, MD
Tiffanie Anderson, APRN
Angela Johnston, PA
Allison Payne, MD

PATIENT INFORMATION

First name _____ Middle _____ Last _____
Birth date _____
Address _____
City _____ State _____ Zip Code _____
Gender ☐ M ☐ F SS# _____
Race ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other Race
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

PHONE NUMBERS

Mother's Cell Phone _____ Other Ph. _____
Father's Cell Phone _____ Other Ph. _____

IN CASE OF EMERGENCY, CONTACT (adult not living with child)

Name _____
Relationship _____
Cell Ph. _____ Other Ph. _____

PARENT/GUARDIAN INFORMATION

First name (mother) _____ Last _____
Maiden _____
Date of Birth _____
Home _____
City _____ State _____ Zip _____
E-mail _____

First name (father) _____ Last _____
Date of Birth _____
Home _____
City _____ State _____ Zip _____
E-mail _____

PRIMARY INSURANCE INFORMATION

Subscriber name _____ Birth date _____
Relationship to patient _____ SS# _____
Insurance company _____
Address _____
ID or group # _____ Second ID or group# _____

SECONDARY INSURANCE INFORMATION

Subscriber name _____ Birth date _____
Relationship to patient _____ SS# _____
Insurance company _____
Address _____
ID or group # _____ Second ID or group# _____

FINANCIAL AGREEMENT: I certify that the above information is correct to the best of my knowledge. The undersigned hereby authorizes the release of any and all information of documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature on each claim submitted for myself and/or dependents. I hereby authorize my insurance company to pay and hereby assign directly to Enid Clinic Inc dba Northwest Pediatrics. I further acknowledge that any insurance benefits, when received and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility in accordance with our contractual agreements with your insurance and when governed by state/federal law. Full payment is due at the time of services unless other arrangements have been made. I understand that I have the primary duty and obligation to pay my doctor for his/her services, notwithstanding any contract I may have with any third party payer (i.e. insurance company, employer, etc.) I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. There is a $35.00 service charge on all returned checks.

HIPAA DISCLOSURE: Enid Clinic Inc dba Northwest Pediatrics shall not publish or otherwise make generally available any protected individually identifiable health information of data that identifies a patient for purposes other than treatment, payment or other health care operations without his/her express written consent. This does not restrict the internal use of such information or data that is required in the performance of the scope of work that this office has been engaged to perform for our patients. This office maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. As our patient, you have the right to request special privacy protections. You have the right to request restrictions on certain uses and disclosure of your health information, by written request specifying what information you want to limit and what limitation on our use or disclosure of that information you wish to have imposed. I hereby acknowledge that this medical practices' Notice of Privacy has been made available to me.

I request the following restrictions to the use and/or disclosure of my health information: _____

I authorize Northwest Pediatrics to render any medical care necessary to my child if I am not available and no other legal guardian is available. ☐ Yes ☐ No

Signature of Patient or Responsible Party	If person signing is not patient, please state relationship	Date
X		