SOUTHEASTERN PEDIATRIC ASSOCIATES, P.A.

Chart No. _____ Today's Date _____

Patient's Complete Name | Sex | Street Address

Patient's SS Number | DOB | Phone | City, State, Zip

Preferred/Primary Language | Race | Ethnicity

FAMILY / RESPONSIBLE PARTY INFORMATION

Father's Complete Name	Mother's Complete Name
Street Address	Street Address
City, State, Zip	City, State, Zip
Home Phone / Work Phone	Home Phone / Work Phone
Social Security #	Social Security #
Birthdate	Birthdate
Employer	Employer
Occupation	Occupation
Employer's Address	Employer's Address
Insurance Company	Insurance Company
Insurance Contract #	Insurance Contract #

PERSON RESPONSIBLE FOR PAYMENT OF ALL BILLS IF DIFFERENT THAN ABOVE*:

Name	Street Address
Social Security # Birthdate	City, State, Zip
Employer	Home Phone / Work Phone
Employer's Address	Insurance Company/Contract #

*** In a divorce situation, it is our policy that whoever brings the child to the office for medical care be responsible for paying the charges at the time of service. Reimbursement should be handled between the parties involved. Both parents are considered equally responsible.**

OVER

CHART # **PATIENT NAME:**

RELATIVE OR NEIGHBOR TO CONTACT IN EMERGENCY

NAME _____ ADDRESS _____

PHONE _____

PREVIOUS SOURCE OF MEDICAL CARE FOR CHILD:

FULL NAME Brothers/Sisters	AGE OR DOB	OTHER HOUSEHOLD MEMBERS FULL NAME	AGE

DO YOU OR ANY OF YOUR CHILDREN HAVE ANY CHRONIC MEDICAL PROBLEMS? N / Y

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Child's current medications: _____

Are there any restrictions on release of your child's medical information: ___ Yes ___ No

If yes, please be specific about restrictions: _____

I certify that I am the parent or authorized agent of the patient and knowledgeable to furnish the information requested. It is understood that copayment is required at the time of the office visit. I authorize the release of any medical or other information necessary (within the guidelines of HIPPAA) to process a claim.

Date Parent of Other Responsible Party

_____ _____