Magnolia Pediatrics

17038 Commerce Centre Drive, Prairieville, LA 70769
Phone: 225.744.4484 Fax: 225.677.9359

As per our contract with your insurance provider, they **REQUIRE** that our office have a **COMPLETED** demographic sheet on file for each patient, every year. If you are unable to provide us with the necessary information, **you will be required to self-pay** until you can do so. Thank you for your cooperation! ☺

Patient's Name: _____ Date of Birth: ____/____/____ Age: ____

Street Address: _____ City: _____ State: ____ Zip: _____

Sex: M/F Home Phone: (_____) - _____-_____

Father's Name: _____ Date of Birth: ____/____/____ Social Security: _____-_____-_____

Employer Name: _____ Work Phone: (_____) - _____-_____

Employer Address: _____ City: _____State: _____ Zip: _____

Home Phone: (_____) - _____-_____ Cell Phone: (_____) - _____-_____ Email: _____

Mother's Name: _____ Date of Birth: ____/____/____Social Security: ____-_____-_____

Employer Name: _____Work Phone: (_____) - _____-_____

Employer Address: _____ City: _____State: _____ Zip: _____

Home Phone: (_____) - _____-_____ Cell Phone: (_____) - _____-_____ Email: _____

Insurance Carrier: _____ Responsible Party: _____

Social Security: _____-_____-_____ Date of Birth: ____/____/____

Insurance Mailing Address: _____City: _____ State: ____ Zip: _____

Insurance Policy Number: _____ Group Number: _____

Relationship to patient: Parent Self Other: _____

Is your child allergic to any Medications (Y/N)? ___ Is your child allergic to any foods, tapes, dye, or other (Y/N)? ___

If yes, please describe the type of allergic reaction: _____

In case of emergency, Contact (different from Parent): _____Date of Birth:_____

Relationship to patient: _____Phone: (_____) - _____-_____

I authorize use of this form, and information on all my insurance submissions, I authorize release of information to my insurance company(ies), I authorize payment directly to my doctor, I understand I am responsible for my bill. I permit a copy of this authorization to be used in place of the original. I authorize my doctor and/or their billing company to act as my agent in helping me to obtain payment from my insurance company (ies). I understand I am responsible for payments in full if my insurance does not cover services.

Sign (Print) _____ Signature _____Date _____