Magnolia Pediatrics

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 (Circle) Primary Contact Number: (_____) _____

If billing address is different than patient address, specify here: _____

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

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

Employer:_____Employer Phone Number:_____

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

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

Employer:_____Employer Phone Number:_____

Responsible party is different than parent: Name: _____ Phone: (____)_____

Address:_____

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

Insurance Carrier: _____ Insurance Subscriber: _____

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

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

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: _____

Emergency contact (other than 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 _____