SPRINGDALE-MASON PEDIATRICS PATIENT INFORMATION:

Children's Names	Birthdate	Sex	If patient is 18 or over we need his/her phone number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Preferred provider (in our practice): _____ Preferred office for appointments: _____

Primary Language: _____

Ethnicity: Unknown / Hispanic or Latino / Non-Hispanic or Non-Latino / Decline to specify

Race: American Indian or Alaskan Native / Asian / Black or African American / Hawaiian / White / Decline to specify

Father's Name: _____DOB: _____ ☐ Biological ☐ Other

Address: _____

City: _____State: _____Zip: _____County: _____

Primary phone: _____ (Home/Cell) Secondary phone: _____ (Home/Cell)

Email Address: _____

Mother's Name: _____DOB: _____ ☐ Biological ☐ Other

Address: _____

City: _____State: _____Zip: _____County: _____

☐ Same as above

Primary phone: _____ (Home/Cell) Secondary phone: _____ (Home/Cell)

Email Address: _____

What is the preferred phone number for the office to call first: _____

For possible future correspondence, what would be the preferred email: _____

Who child resides with: _____ Who should receive billing statements: _____

(current address must be provided)

Do you have insurance? ☐ Yes ☐ No

Insurance Company Name(s): _____ Subscriber: _____

Policy Number: _____ Group #: _____

I confirm that the above information is complete and accurate. I acknowledge that the HIPPA Compliance Privacy Policy was made available to me. I also authorize Springdale-Mason Pediatrics to submit a claim to my insurance carrier for all services rendered and direct my insurance carrier to issue payment directly to Springdale- Mason Pediatrics. I understand that I am financially responsible to the office for any balance not covered by my insurance carrier.

Signature: _____ Date: _____