South County Pediatric Associates

Irma Ortiz-Arroyo, MD Maria Baszis, MD Teresa Kurtz, MD

4850 Lemay Ferry Road Suite 120
Saint Louis, MO 63129
314-849-3320 / Fax: 314-849-7766

Today's Date:______________________________ **Primary Physician:** ________________________________

Patient's Name:____________________________________ **Male/Female** **Date of Birth:**_______________
Last M.I. First

Other Children that will be seen in this office:

Last Name **First Name** **M/F** **D.O.B.**

1).____
2).____
3).____
4).____

Preferred Pharmacy:______________________________________ **Phone Number:**________________________

Name/Address of Responsible Parent/Guardian to Bill:

____

Mother's Name:	______________________________	**Father's Name**	__________________________________
SS #:	______________________________	**SS #:**	__________________________________
Date of Birth:	______________________________	**Date of Birth:**	__________________________________
Address:	______________________________	**Address:**	__________________________________
	_______________**Zip** ___________		____________________**Zip**____________
Cell Phone #:	______________________________	**Cell Phone #:**	__________________________________
Email Address:	______________________________	**Email Address:**	__________________________________
Employer:	______________________________	**Employer:**	__________________________________
Work Phone #:	______________________________	**Work Phone #:**	__________________________________

If parents are divorced or separated please fill out this section:
Who has custody? ____________________________
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.
____
____

Insurance Information

Primary Policy: Policy Holder's Name: ______________________________

Insurance Carrier: ______________________ Policy ID#: ______________________

Group #:______________________ Gender: Male/Female

Secondary Policy: Policy Holder's Name: ______________________________

Policy Holder's Birth Date: ______________ Policy Holder's SSN: ________-______-_______

Insurance Carrier: ______________________ Policy ID#: ______________________

Group #:______________________ Gender: Male/Female

Consent for Treatment in My Absence: I hereby give South County Pediatrics Associates advance consent to any medical procedure for the above named child(ren) in the event that I am unable to accompany him or her to the office and he or she is accompanied by one of the following:

1: ______________________ Relationship ______________ Phone: (___) _____ - _________

2: ______________________ Relationship ______________ Phone: (___) _____ - _________

Signature of Parent/Guardian:______________________________ **Date**: ______________

Consent to Treat: I hereby give South County Pediatrics Associates or their designee authority to administer treatment to the above named child(ren).

Signature of Parent/Guardian:______________________________ **Date**: ______________

Financial Responsibility: I hereby assign all medical and/or surgical benefits to which I am entitled through private insurance for my dependents to South County Pediatrics Associates. I understand that I am responsible for the charges incurred with my child's care. In the event that insurance fails to cover these charges, I understand that I am responsible for all charges. I will be responsible for collection costs and attorney fees associated with the cost of resolving my account. I also consent to release of any information to my insurance company or their designated representatives for claims processing or any other purpose for which they may request copies of medical records. This release will remain valid unless I revoke it in writing to South County Pediatrics.

Signature of Parent/Guardian:______________________________ **Date**: ______________