___ Initial here if you give consent to receive a text for appt reminders

SOUTHERN OREGON PEDIATRICS

www.sopeds.com
750 MURPHY ROAD MEDFORD, OR 97504
(541) 789-4096

Please fill in the following information completely. Please print.

PATIENT INFORMATION:

Patient Name_____**DOB**_____ **M / F**
Last name First name Middle name

Street Address_____**City**_____ **State**_____ **Zip**_____

Home Phone _____**Cell Phone number**_____ **Social Security #** _____
(If patient has one)

Patient's Ethnicity: Hispanic/Latino___ Non-Hispanic/Latino___ Unknown___

Patient's Race (mark all that apply): White/Caucasian____ Native Hawaiian or other Pacific Islander____ Black/African American____
American Indian or Alaska Native____ Asian____ Unknown____

Patient's Siblings

_____ **DOB**_____ **M / F** _____ **DOB**_____ **M / F**
Name Name
_____ **DOB**_____ **M / F** _____ **DOB**_____ **M / F**
Name Name
_____ **DOB**_____ **M / F** _____ **DOB**_____ **M / F**
Name Name

PERSON RESPONSIBLE FOR PATIENT:

Birth or Adoptive Father's Name: _____ **DOB**_____**SS#**_____

Address (if different from patient) _____Phone/Cell # _____

Employer Name _____Work Phone Number _____Can you be reached there? Y or N

Birth or Adoptive Mother's Name _____**DOB** _____**SS#**_____

Address (if different from patient) _____ Phone/Cell# _____

Employer Name _____ Work Phone Number _____ Can you be reached there? Y or N

Legal Custodian (if above N/A) _____ DOB _____SS# _____Relation _____
Address (if different than above) _____Phone/Cell # _____

Employer Name _____ Work Phone Number_____ Can you be reached there? Y or N

FOSTER PARENT INFORMATION: (IF APPLICABLE)

Name of Guardian: _____Phone/Cell # _____

Address: _____ DOB _____

EMERGENCY CONTACT INFORMATION:

Who can we contact in the event of an emergency if we are not able to reach the parties listed above?
Name_____ Phone Number_____ Relationship to Patient_____

AUTHORIZATION TO TREAT/PAY/RELEASE MEDICAL INFORMATION

I authorize treatment of the patient listed above. I hereby assign all payments to Southern Oregon Pediatrics for which I am entitled for medical and surgical expenses related to the services performed by them and direct that checks for such services be made to them. I have supplied Southern Oregon Pediatrics with my current insurance coverage information, I also authorize the above physician to release such information (including a copy of this form) as may be required by my INSURANCE COMPANY and/or REFERRING DOCTOR and/or any Practitioner the doctor may refer the patient to. In addition, I accept financial responsibility for services provided for the patient named above until I give written notice to terminate this agreement. I understand that if the information I have provided Southern Oregon Pediatrics is not sufficient to bill my insurance or if the patient's services are not paid by my insurance within the contract limits, I will be responsible for the outstanding balance, if any. I deem this authorization to be in effect until revoked in writing by myself.

Signature of Parent/Guardian_____**Date**_____