

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

SOUTHERN OREGON PEDIATRICS

www.sopedes.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 _____