NORTH OAKS PEDIATRIC CLINIC, LLP

Today's Date: ____________________ Please Fill In Every Space. A Complete Record Is Needed For Each Child. Thanks.

Office use Only

Patient's Last Name: ____________ First: ____________ Middle: ____________

Street Address: ____________ City: ____________ State: ______ Zip: ______

Phone: ____________ Date of Birth: ____________ Age: ______ Sex: ______ Race: ______

Patient's Social Security Number: ____________ Name Which Patient Goes By: ____________

Office use Only

Mother's Name: ____________ Social Security Number: ____________

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed Date of Birth: ____________

Mother's Mailing Address: ____________ City: ____________ State: ______ Zip: ______

Physical Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Occupation: ____________ Place of Employment: ____________

Office use Only

Father's Name: ____________ Social Security Number: ____________

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed Date of Birth: ____________

Father's Mailing Address: ____________ City: ____________ State: ______ Zip: ______

Physical Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Occupation: ____________ Place of Employment: ____________

Office use Only

Step Mother's Name: ____________ Social Security Number: ____________

Date of Birth: ____________

Step Mother's Mailing Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Occupation: ____________ Place of Employment: ____________

Office use Only

Step Father's Name: ____________ Social Security Number: ____________

Date of Birth: ____________

Step Father's Mailing Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Occupation: ____________ Place of Employment: ____________

Nearest Relative
Not Living at Same Address: ____________ Relationship to Patient: ____________ Phone: ____________

IN CASE OF EMERGENCY, WHOM SHOULD
WE NOTIFY, other than the parents listed above? ____________ Phone: ____________

List All Brothers and Sisters of This Patient (Include Step - and half - Brothers and Sisters)

Full Name	Date of Birth	Full Name	Date of Birth

Is this the first time that any family member has been seen here? _____ Yes _____ No

If YES, How did you hear about our practice?

Last Physician to care for this patient: ____________

Why Did You Change?

Who Is Responsible For This Patient's Medical Bills? ☐ Father ☐ Mother Other: ____________

INSURANCE INFORMATION

Primary
Insurance Carrier: ____________ Policy Number: ____________ Employer Name: ____________

Policy Holder's Name: ____________ SSN # ____________

Date of Birth: ____________ Relationship to Patient: ____________ Phone Number: ____________

Secondary
Insurance Carrier: ____________ Policy Number: ____________ Employer Name: ____________

Policy Holder's Name: ____________ SSN # ____________

Date of Birth: ____________ Relationship to Patient: ____________ Phone Number: ____________

I HAVE BEEN GIVEN A COPY OF THIS OFFICE'S FINANCIAL POLICY AND I UNDERSTAND THAT OFFICE SERVICES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED.

SIGNATURE OF PARENT: DATE:

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN MY INSURANCE BENEFITS UNDER THE ABOVE PLANS FOR TREATMENT RENDERED TO THE ABOVE NAMED CHILD BY THE PHYSICIANS OF THE NORTH OAKS PEDIATRIC CLINIC, LLP, HAMMOND, LA. THIS ASSIGNMENT IS EFFECTIVE UNTIL REVOKED BY ME IN WRITING, AND A PHOTOCOPY SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. I AUTHORIZE THE CLINIC TO RELEASE ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR ME.

SIGNATURE OF PARENT: DATE: SIGNATURE OF PARENT: DATE:

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