Stone Spring Pediatrics, LLC

Patient's Name____DOB:_________Gender:__________

Address_________________________________City:___________________State:_____Zip:_____

Insurance:_____________________________Guarantor:___________________________________
Primary Pharmacy:________________________Location:__________________________________
Preferred Language:_______________________Do you need an interpreter? Yes No

Race: American Indian/Alaskan Native
Asian
Black/African American
Hawaiian/Pacific Islander
Other
White
Hispanic or Latino Origin? Yes No

Mother:____SS# ___________________
Address_________________________________City:___________________State:_____Zip:_____
Phone: (H)________________(W)________________(C)________________
Mother's DOB:_______________________Employer:_______________________________________

Father:____SS# __________________
Address_________________________________City:___________________State:_____Zip:_____
Phone: (H)________________(W)________________(C)________________
Father's DOB:_______________________Employer:______________________________________

Other siblings that are patients here:____

Emergency contact (other than parent)____
Relationship to patient:_________________________Phone #:______________________________

SIGNATURE ON FILE

I understand that **I am responsible** for my bill.
I authorize the use of this form on **all** my insurance submissions.
I authorize release of information to all my **insurance companies**.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

Child's Name:____

Signature of Card Holder:____Date:______________________

Date of birth of cardholder:______________________________________
Relationship of cardholder to patient:____
Employer of cardholder:____