Southwest Children's Clinic, LLC – Patient/Family Information Form

	First Child	Second Child	Third Child	Fourth Child
First Name				
Middle Initial				
Last Name				
Sex (M/F)				
Primary Language Spoken (If not English)				
Ethnicity	___ Not Hispanic ___ Hispanic ___ Unknown ___ Choose not to Answer	___ Not Hispanic ___ Hispanic ___ Unknown ___ Choose not to Answer	___ Not Hispanic ___ Hispanic ___ Unknown ___ Choose not to Answer	___ Not Hispanic ___ Hispanic ___ Unknown ___ Choose not to Answer
Race (Check all that apply)	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander ___ Choose not to Answer	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander ___ Choose not to Answer	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander ___ Choose not to Answer	___ Native American ___ Black ___ Asian ___ White ___ Pacific Islander ___ Choose not to Answer
DATE OF BIRTH				

Residence Address: _____ Primary Phone: (_____) _____ - _____

Primary Phone for child/children may be a "home" phone or a cell phone.

_____

Does this Residence Address and Primary Phone apply to all children shown? **Yes** **No** (Circle one. If No, provide necessary information here.)

Primary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: _____/_____/_____

Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

Insurance ID Number:_____Effective Date of Plan: _____/_____/_____

Secondary Insurance – Please present card to be scanned

Policyholder's Full Name: _____ Policyholder's Date of Birth: _____/_____/_____

Insurance Plan Name: _____ Policyholder's Relationship to Patient: _____

Insurance ID Number:_____Effective Date of Plan: _____/_____/_____

*** Who is the Policy holder for Insurance?** _____

*** Who is the Financial Guarantor (person who receives billing statements)?** _____

(Financial Guarantor must be included in Contacts on page 2.)

Does this apply to all children? _____ (If no, provide other necessary information here.)

Contacts

	First Contact (Parent/Guardian)	Second Contact (Parent/Guardian)
Full Name		
SSN- **last four digits only**		
Relationship to Patient(s)?		
Resides with Patient(s)?		
Street Address		
Address: City, State, Zip		
Birth Date		
Primary Phone: ("Home" phone)		
Work Phone:		
Cell Phone:		
Email: Must be unique to Contact		
Contact may have access to Patient Portal for all children? (Yes or No)		
Is this Contact preferred for reminders?		
Preferred method of Contact (Circle one preference for each reason)	**Medical Issues:** Call-Cell Call-Primary Phone TEXT Appointments: Call- Cell Call Primary Phone TEXT	**Medical Issues:** Call-Cell Call-Primary Phone TEXT Appointments: Call-Cell Call Primary Phone TEXT

- *If Patient is 18 or older, Include Contact Info for Patient. Please use another form if more Contact space is needed.*

Emergency Contact for listed children (other than Contacts listed above):

Name _____ Relationship to Patient(s) _____ Phone (_____) ____-_____

Please list anyone else authorized to be your representative and bring your child(ren) to appointments:
I understand I can change or revoke the below authorization at any time but I can't change or revoke names given by another parent.
Name _____ Relationship to Patient(s) _____ Phone (_____) ____-_____

Name _____ Relationship to Patient(s) _____ Phone (_____) ____-_____

I acknowledge that the **Financial Policy** and **Notice of Privacy Practices** are available in the office and on our website. Copies are available upon request. I understand both biological parents have access to full disclosure (even if not the custodial parent) and both can authorize representatives unless parental rights have been terminated by court order. I understand if there are Custody Orders in place, I must present current copies for my child's file. I authorize the people listed to bring my child to any appointments in my absence and Southwest Children's Clinic may call and leave a message regarding my child's clinical care, including lab and x-ray results in my absence. I understand this authorization for release of information will remain in effect until parent or guardian changes their disclosure with Southwest Children's Clinic in writing. At that time this authorization will expire. I authorize Southwest Children's Clinic. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers, my health insurance, my attorney, and/or other health practitioners. I authorize my insurance plan to make direct payment of medical benefits, to include major medical benefits, to Southwest Children's Clinic. I understand Southwest Children's Clinic provides immunization information to the Utah State Immunization Information System. I understand that I am personally responsible for being aware of the dates and times of my scheduled appointments. I hereby authorize the doctors of Southwest Children's Clinic to be attending physicians and to administer any examination, treatment, and medications he/she deems therapeutic to presenting complaint.

Signature _____ Relationship to Patient(s) _____ Date _____