8100 W. 119th Street
Palos Park, IL 60464
708-361-3300

SWP southwest pediatrics

9400 Bormet Drive
Mokena, IL 60448
708-479-7337

Please complete this entire form and present your insurance cards to be scanned into our system.

Up-to-date information is critical for each patient in order to correctly process insurance claims and necessary referrals. Periodically, we will ask that you verify this information. **It is your responsibility to notify us of any changes.**

Please list all children at SWP who share the same demographics. (i.e. Insurance, parents, address, etc.)

Last Name, First Name	Birth Date	Sex	Last Name, First Name	Birth Date	Sex
		M or F			M or F
		M or F			M or F
		M or F			M or F

Address: _____ Home # (____) _____
City, State, Zip: _____ Preferred Cell (____) _____

How do you wish to be contacted: **(Please circle one)** Home or Preferred Cell
May we leave a message? Y or N If Yes: **(Circle One)** EXTENDED or BRIEF

RACE: (Please circle one)
American Indian or Alaska Native - Asian - White
Native Hawaiian Or Other Pacific - Black or African American
Hispanic - Other Race - Unreported/Refused to Report

Do you speak English? Y or N
If NO specify Language: _____
ETHNICITY: (Please circle one)
Hispanic/Latino - Non-Hispanic/Latino - Refuse to Report

Father's Name: _____
DOB: _____ Cell #: (____) _____
E-Mail: _____
Occupation: _____ Work #: (____) _____
Preferred E-mail for Child: Mom Dad **(Circle One)**
Please circle below if this information is the same as child's.
SAME
Address: _____
City, State, Zip: _____
Home #: (____) _____

Mother's Name: _____
DOB: _____ Cell #: (____) _____
E-Mail: _____
Occupation: _____ Work #: (____) _____
Please circle below if this information is the same as child's.
SAME
Address: _____
City, State, Zip: _____
Home #:: (____) _____

Emergency Contact (Other than parent) **:**
Relation: _____
Home Phone: (____) _____
Last Name: _____
First Name: _____
Cell No: (____) _____

PHARMACY 1
Pharmacy Name : _____
Address: _____
City: _____ State: _____
Tel #: (____) _____

PHARMACY 2 (if applicable)
Pharmacy Name : _____
Address: _____
City: _____ State: _____
Tel #: (____) _____

PRIMARY Insurance Carrier/Guarantor:
Ins. Co. Name: _____
Policy Holder Information: PPO or HMO
Name: _____
SS# ____/____/____
Relationship to patient: Parent Guardian Other
Ins. ID#: _____ Grp#: _____
COPAY: Office Visit: $ _____ Wellness/Preventive:$_____

SECONDARY Insurance Carrier
Ins. Co. Name: _____
Policy Holder Information: PPO or HMO
Name: _____
SS# ____/____/____
Relationship to patient: Parent Guardian Other
Ins. ID#: _____ Grp#: _____
COPAY: Office Visit $ _____ Wellness/Preventive: $_____

I give Southwest Pediatrics, Ltd authorization to release information to my insurance company and to assign benefits to them in accordance with HIPAA regulations. I understand that regardless of my insurance, I am financially responsible for the fees for services rendered and all collection fees if applicable. I also understand that a copay is due at the time of service, if required by my insurance company. **SIGNATURE** _____ **DATE** _____
PRINT NAME _____ **Relationship to Patient:** _____

Electronic Health eXchange (EHX) **Opt** ____ **IN** ____ **OUT** _____ _____
(See office brochure or SWP website for details.) **Parent Signature** **Date**

Over- Notice of Privacy Practices Receipt ➡

southwest pediatrics

Bey-Yu C. Hilgart, M.D.
Prashant G. Deshpande, M.D.
V. Grace Carreon, M.D.
Jonathan L. Belgrad, M.D.
Elizabeth C. Stringer, M.D.
Surasak Pratuangtham, M.D.

NOTICE OF PRIVACY PRACTICES RECEIPT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I HAVE RECEIVED THE ATTACHED COPY OF SOUTHWEST PEDIATRICS, LTD's PRIVACY PRACTICES THAT BECOME EFFECTIVE ON MARCH 3, 2003.

Last Name, First Name (Please list each child)	**Birth Date**	**Date**

Print Name of Parent/Legal Guardian _____ **DATE** _____

Signature or Parent/Legal Guardian _____ **DATE** _____

Witness _____ **DATE** _____

Southwest Pediatrics, LTD.
1 Park Place
8100 W. 119th Street
Palos Park, IL 60464
(708) 361-3300
Fax (708) 361-8139

9400 Bormet Drive
Mokena, IL 60448
(708) 479-7337
Fax (708) 361-8139

Answering Service
(708) 857-2844

www.southwestpeds.com

FOR OFFICE USE ONLY:
I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:
DATE: _____ INTIALS _____ REASON: _____