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 ➡