SOUTHWEST PEDIATRICS, LTD.

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

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

Please complete this entire form and present your insurance cards. *We need up-to-date information in each patient's chart and occasionally may ask that you verify this information. It is your responsibility to notify us of any changes.*

Patient Name: _____ Sex M F DOB: ___/___/____

Address: _____

City, State, Zip: _____

Phone Contact :
(_____)_____

Email Contact: _____

Parent 1 Name: _____

Address: _____

City, State, Zip: _____

Home Phone: (_____)_____

Cell Phone:
(_____)_____

Occupation: _____

Date of Birth: _____

Parent 2 Name: _____

Address: _____

City, State, Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Occupation: _____

Date of Birth: _____

How do you wish to be contacted: (Please circle.) Home Work Cell **Phone number chosen:** (_____)_____
May we leave a detailed message? _____YES ____NO

Emergency Contact: _____ Relationship: _____ Phone: (_____)_____
(Other than parent)

Person responsible for payment (such as: Parent, Guardian, Other) Include home mailing address.

Name: _____

Address (City, State, Zip): _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

PRIMARY Insurance Carrier

Ins. Co. Name: _____

Pls. identify plan: (PPO / HMO)_____

Policy Holder Information:

Name: _____

Sex M F DOB: ___/___/___ SS# _____/___/_____

Relationship to patient: Parent Guardian Other

Ins. ID#: _____ Grp#: _____

Effective Date: _____

Employer (*of Ins Policy Holder*): _____

SECONDARY Insurance Carrier

Ins. Co. Name: _____

Pls. identify plan: (PPO / HMO) _____

Policy Holder Information:

Name: _____

Sex M F DOB: ___/___/___ SS# _____/___/_____

Relationship to patient: Parent Guardian Other

Ins. ID#: _____ Grp#: _____

Effective Date: _____

Employer (*of Ins Policy Holder*): _____

Preferred Pharmacy

Name: _____

Address (City, State, Zip): _____

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 ____ Signature: _____ Date: _____

Prashant G. Deshpande, M.D.
V. Grace Carreon, M.D.
Jonathan L. Belgrad, M.D.
Surasak Pratuangtham, M.D.
Elizabeth C. Stringer, M.D.
Kelsey Heroux, M.D.
Mallory Berg, FNP-C

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 _____ Birth Date _____ Date _____

Print Name of Parent/Legal Guardian _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____

Witness _____ Date _____

FOR OFFICE USE ONLY:

I ATTEMPTED TO OBTAIN THE PATIENT/PARENT SIGNATURE IN ACKOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES, BUT WAS UNABLE TO DO SO.

Date: Initials: Reason:

Southwest Pediatrics, Ltd.

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

9400 Bormet Drive
Suite 4
Mokena, IL 60448
(708) 479-7337
Fax (708) 361-8139

24/7 Answering Service
Palos (708) 361-3300
Mokena (708) 479-7337

www.southwestpeds.com