Southern Pediatric Clinic, LLC
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Pediatrics and Adolescent Medicine

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Patient Application Form

Today's Date _____

Child's Name _____ Birthdate _____ Sex M / F

Address _____ Zip Code _____ Social Security # _____

Preferred language ☐ English ☐ Spanish ☐ Other: _____

Name & birthdates of child's brothers and/or sisters (include last name if different)

Has your child ever been seen at our practice? ☐ **YES** ☐ **NO**

Have any of your child's brothers and/or sisters ever been seen at our practice? ☐ **YES** ☐ **NO**

If yes, which brothers or sisters? _____

What was your reason for leaving the practice? _____

If your child (or children) has not been seen before, who may we thank for referring you to our office? _____

Name of child's current doctor _____

Name of child's previous doctor _____

Name of parents' family doctor _____

REASON FOR CHANGING PROVIDERS _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD

Primary Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

WE BELIEVE IN VACCINATING OUR PATIENTS
BY SIGNING BELOW YOU ARE AGREEING TO ALLOW US TO VACCINATE YOUR CHILD

Parent/Guardian Printed Name	Signature	Date