Northern Oklahoma Regional Pediatric Clinic, PLLC

Ahmad S. Agha, M.D. ● Michael S. Walker, M.D. ● Peter Sinton, M.D. ● Brenda Peters, APRN-CPNP ● Lacey Brewer, APRN-CPNP

PATIENT INFORMATION

(Last) (First) (MI)

(Date of Birth) (Sex) (S.S.#) (Primary Cell Phone) & (Cell Phone Carrier)

(Address) (City) (State) (Zip)

Race: (Circle one) White African American Am. Indian/Eskimo Hispanic Asian/Pac Islander Other
Ethnicity: (Circle one) Not Hispanic/Latino Hispanic/Latino **Preferred Language:** (Circle one) English Spanish

Father
(Last) **(First)** **(MI)** **(Social Security #)**

(Date of Birth) Marital Status: S M W D (Address) (City) (Zip Code)

(Home/Cell Phone) **(Email)** @

Employment Information

(Supervisor Name) **Business Name** (Address) (City) (Zip Code)

(Work Phone)

Mother
(Last) **(First)** **(MI)** **(Social Security #)**

(Date of Birth) Marital Status: S M W D (Address) (City) (Zip Code)

(Home/Cell Phone) **(Email)** @

Employment Information

(Supervisor Name) **Business Name** (Address) (City) (Zip Code)

(Work Phone)

Guardian/Other
(Last) **(First)** **(MI)** **(Social Security #)** **(Date of Birth)**

(Relationship to Patient) **(Home/Cell Phone)** **(Work Phone)**

(Address) (City) (Zip Code)

Employment Information

(Supervisor Name) **Business Name** (Address) (City) (Zip Code)

(Work Phone)

Siblings

(Last)	(First)	(Date of Birth)	(Last)	(First)	(Date of Birth)
(Last)	(First)	(Date of Birth)	(Last)	(First)	(Date of Birth)
(Last)	(First)	(Date of Birth)	(Last)	(First)	(Date of Birth)

PRIMARY INSURANCE INFORMATION

(Name of Insurance Company) or (Medicaid) (Name of Policy Holder) & (Date of Birth) (Policy #) or (Medicaid ID#)

Please bring insurance card to your appointment **If there is a secondary insurance please present card**

EMERGENCY INFORMATION (Other than listed above and not living with you)

(Name) (Relationship) (Phone Number)

(Address) (City) (Zip Code)

GUARANTOR'S FINANCIAL STATEMENT

I understand that all services rendered, including reasonable attorney's fees and costs of collections in the event of default are my financial responsibility and that payment is due at the time of service **unless** prior arrangements have been made. I authorize the release of any medical or other information necessary to processing insurance claim, and also authorize payment of medical benefits directly to the physician for services rendered.

(Guarantor's Signature) (Date)