SOUTHLAKE PEDIATRICS

Edward (Butch) Goldblatt, M.D.
Andrew N. McCown, M.D.
Anne W. Byars, M.D.

Date: _____

Please list all children seen at this practice:

Name: _____ Sex: ___M ___F Date of Birth: _____
Drug Allergies? _____
Name: _____ Sex: ___M ___F Date of Birth: _____
Drug Allergies? _____
Name: _____ Sex: ___M ___F Date of Birth: _____
Drug Allergies? _____
Name: _____ Sex: ___M ___F Date of Birth: _____
Drug Allergies? _____
Name: _____ Sex: ___M ___F Date of Birth: _____
Drug Allergies? _____

Children(s) Home Address: _____

City: _____ State: _____ Zip: _____

Mother's Name: _____ DOB: _____ **Father's Name**: _____ DOB: _____

Mother's Place of Employment: _____ Mom's Social Sec# _____

Father's Place of Employment: _____ Dad's Social Sec# _____

Mother's address if different: _____

Father's address if different: _____

If child doesn't live with parents, who is the primary caretaker? _____

Is this custody arrangement temporary or permanent? _____ Primary Caretaker's # _____

Contact Information

Phone Number	OK to leave message?	Phone Number	OK to leave message?
Home: _____	☐ Yes ☐ No	Patient's cell: _____	☐ Yes ☐ No
Mom cell: _____	☐ Yes ☐ No	Mom work: _____	☐ Yes ☐ No
Dad cell: _____	☐ Yes ☐ No	Dad work: _____	☐ Yes ☐ No
		Guardian: _____	☐ Yes ☐ No

Primary caretaker's name and email address: _____

Emergency contact (Someone NOT in the home): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance #1 (Primary): _____ Co-Pay: _____ Contract#: _____

Insurance #2 (Secondary): _____ Co-Pay: _____ Contract#: _____

CONSENT OF TREATMENT – RELEASE OF MEDICAL INFORMATION – FINANCIAL RESPONSIBILITY

I consent to treatment for the care of the above named patient. I hereby authorize release of any or all medical records to the referring physicians, my insurance carriers, or those involved in payment of my account. I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Southlake Pediatrics, Inc. In the event an account is not paid within 90 days, I agree to pay collection fees ($10 certified mail fee, reasonable collection agency fees not to exceed 33 1/3% & possibly attorney's fees) and hereby waiver all rights of exemption under the constitution of the state of Alabama.

Date: _____ Signed: _____ Parent _____ Foster Parent_____ Guardian_____