200 Liberty Avenue Lafayette, LA 70508 PH: (337) 989-8080 FAX #: (337) 981-0913
www.solapediatrics.com

Patient Information:

Last Name: _____ First Name: _____ Middle _____

Date of Birth: ___/___/_____ Sex: Male Female Primary Language _____

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Who does the child live with? (Name/Relationship)
Mother/Father/Other_____

Primary Contact: _____ (Relationship)
Last Name:_____ First Name: _____ Middle _____
Mailing Address:
_____

_____

Lives with patient? Yes / No Date of Birth ___/___/____
Work Phone: (____) ____--_____ Cell Phone (____) _____--_____ Home Phone: _____

Home Email: _____ Social Security #: _____- ____-_____

Employer: _____ Occupation: _____

How would you like to be contacted for the following:

Medical issues: Home Phone / Work Phone / Cell Phone / Home Email
Appointment Reminders: Home Phone / Work Phone / Cell Phone / Home Email
Recall Notices: Home Phone / Work Phone / Cell Phone / Home Email
Billing Statements: Home Phone / Work Phone / Cell Phone / Home Email
General Practice Notices: Home Phone / Work Phone / Cell Phone / Home Email
Patient Portal Notifications: Email

2nd Contact:_____(Relationship)

Last Name:_____ First Name: _____
Mailing Address:
_____

_____

Lives with patient? Yes / No Date of Birth ___/___/____
Work Phone: (____) ____--_____ Cell Phone (____) _____--_____ Home Phone: _____

Home Email: _____ Social Security #: _____- ____-_____

Employer: _____ Occupation: _____

Insurance:

Insurance Carrier: _____ Insured SSN#: _____ - _____ - _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ Birth Date: ___/ ___/ _____

Relationship to patient: ____ Mother ____Father ____Self _____Other

Secondary Insurance:

Insurance Carrier: _____ Insured SSN#: _____ - _____ - _____

ID#: _____ Group #: _____

Policy Holder's Name: _____ Birth Date: ___/ ___/ _____

Relationship to patient: ____ Mother ____Father ____Self _____Other

Who should the Billing Statements go to? _____
If parents are divorced :
Who has custody? _____ Custody papers on file Yes / No
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?
Yes / No If yes, explain & provide legal papers: _____

Continued:

Siblings:

Name: _____ DOB: ___/ ___/ ____ Male ___ Female ___

Name: _____ DOB: ___/ ___/ ____ Male ___ Female ___

Name: _____ DOB: ___/ ___/ ____ Male ___ Female ___

Name: _____ DOB: ___/ ___/ ____ Male ___ Female ___

How did you hear of our practice?

_____ TV Commercial _____ Another Doctor

_____ Internet _____ Ad in books, bulletins, etc

_____ Friend _____ Other: _____

Notice of Privacy Practices:

I authorize the doctors at Sola Pediatrics, LLC to treat my child/children to the best of their ability. I hereby authorize payment of insurance benefits directly to Sola Pediatrics, LLC or in the name of the practicing doctors. I understand I am financially responsible for all charges, whether paid by insurance company or not for all services rendered on my behalf or my dependents. I authorize the above provider of services in this office to release any information required to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use any disclosure of my information for the purposes described.

_____ _____

Print name Date

_____ _____

Signature Relationship to patient