PLEASE DO YOUR BEST TO FILL IN EVERY SPACE
BEACH PEDIATRICS - REES STEPHENS, INC.

Referred to our office by: _____ DATE: _____

Responsible Party Information

Name (Last, First, MI): _____
Date of Birth: _____ Occupation: _____ Sex: _____
Street Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone: ( ) _____
Cell Phone: ( ) _____
Employer: _____ Work Phone: ( ) _____
Employer Address: _____ City:_____
Driver's License #: _____ Social Security #: _____
Marital Status Please Circle: Single Married Widowed Divorced Separated
Relationship to Patient: _____

Other Parent Information

Name (Last, First, MI): _____
Date of Birth: _____ Occupation: _____ Sex: _____
Street Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone: ( ) _____
Cell Phone: ( ) _____
Employer: _____ Work Phone: ( ) _____
Employer Address: _____ City: _____
Driver's License #: _____ Social Security #: _____
Relationship to Patient: _____

Patient Information (Please list all Children)

Name (First, MI, Last) Sex SSN DOB
(1) _____
(2) _____
(3_____
(4) _____

Insurance

Primary Insurance: _____ Insured Person: _____
ID Number: _____ Group Number: _____
Secondary Insurance: _____ Insured Person: _____
Id Number: _____ Group Number: _____

Emergency Contact – Friend or Relative Not Living With You

Name: _____ Relationship _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: ( ) _____

In case your child (ren) should need medical treatment and come in or are brought in by persons other than parents. Please sign below if you give your consent for your child (ren) to be treated in your absence by the physician.

_____ Date: _____
Please list person (s) authorized to bring child (ren) in _____
_____ _____ _____

THIS AUTHORIZATION IS VALID FOR ONE (1) YEAR ONLY FROM THE DATE OF SIGNATURE.