

**Magnolia Pediatrics**  
17503 Old Jefferson Hwy, Prairieville, La. 70769  
Phone (225) 744-4484 Fax 225-677-9359

**Patients Name:** \_\_\_\_\_ **Date of Birth** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_\_\_

**Sex:** M / F    **SSN#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    **Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Referred by (How did you hear about us?)** \_\_\_\_\_ **Email** \_\_\_\_\_

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**Father's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Social Security** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Employer Name:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Ext.** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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**Mother's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Social Security** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Employer Name:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Ext.** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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**Responsible Party/Insured:** \_\_\_\_\_ **Phone :**( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Insurance Company Name:** \_\_\_\_\_ **Insurance Company Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Claims Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Insurance Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Relationship to patient :**    **Parent**    **Self**    **Other:** \_\_\_\_\_

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**Is your Child allergic to any Medications (Y/N)?** \_\_\_ **Is your child allergic to any foods,tapes,dye,or other (Y/N)?** \_\_\_ **If yes, Please describe the type of allergic reaction:** \_\_\_\_\_

**In case of emergency Contact (different from Parent):** \_\_\_\_\_ **Phone :**(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Signature on file**

**I authorize the use of this form , and information on all my insurance submissions, I authorize release of information to my insurance company(ies), I authorize payment directly to my doctor, I understand I am responsible for my bill, I permit a copy of this authorization to be used in place of the original, I authorize my doctor to act as my agent in helping me to obtain payment from my insurance company(ies), I understand I am responsible for payment in full if my insurance does not cover services.**

**Name(print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_