# Owasso Pediatric and Adolescent Medicine
# Patient Profile

Doctor:_______________________________

**PATIENT INFORMATION**

Name: ________________________________________________________________ Patient ID #: _____________ Sex: [ ]M [ ]F
First Middle Last

Address: ______________________________________________________________ Date of Birth:_____________

______________________________________________________________ Race:___________________

City,State: ______________________________________________________________ Primary Language :_________________________

Email:_________________________________________________________________ Social Security #: _______________________________

Phone: __________________________________________ [ ]Home [ ]Work [ ]Other [ ]Cell (**PREFERRED CONTACT NUMBER)**

Phone: __________________________________________ [ ]Home [ ]Work [ ]Other [ ]Cell

Phone: __________________________________________ [ ]Home [ ]Work [ ]Other [ ]Cell

Mother's Full Name: ________________________________________________ Father's Full Name
____________________________________________

Mother's Date of Birth : ______________________ Father's Date of Birth : ______________________

Mother's Social Security #: __________________________ Father's Social Security #: _______________________________

**GUARANTOR** **(Provider of Insurance and Payments)**

Name: _________________________________________________________________

Relationship to Patient: ______________________________________________________

I authorize direct payment to be made to the office of Owasso Pediatric and Adolescent Medicine for any and all medical or surgical services rendered. I understand that if any of services or charges are not covered, or if Owasso Pediatric and Adolescent Medicine is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I also authorize the release of any medical records for the purpose of healthcare operations.

__________________________________________________________________________
Signature of patient or guardian Date