

NEW PATIENT INFORMATION

COTTONWOOD PEDIATRICS WWW.COTTONWOODPEDS.COM 700 MEDICAL CENTER DR, STE 150 NEWTON, KS | 67114 P:316-283-7100 | F:316-283-7118

CHILD'S FIRST NAME	MIDDLE		LAST	
DATE OF BIRTH (MM/DD/YYYY)	FEMALE	MALE STREET ADD	DRESS	
ZIP CODE CITY	STATE	MAILING ADDRESS	IF DIFFERENT	
SOCIAL SECURITY # MAIN	N PHONE #	(OTHER PHONE #	
RACE ETHNICITY		LANGUAGE		
I DECLINE TO STATE MY CHILD'S RACE/ETHNICITY/LANGUAGE (PLEASE INITIAL)				
PARENT INFORMATION				
FULL NAME		DC	DB (MM/DD/YYYY)	
FEMALE MALE SOCIAL SECURITY #		SAM	e address as child?	es no
MAILING ADDRESS IF DIFFERENT	ZIP CC	DDE	CITY	STATE
EMAIL PLACE OF EMPLOYMENT				
SAME PHONE # AS CHILD? YES NO PHONE # (IF DIFFERENT)				
FULL NAME			DB (MM/DD/YYYY)	
FEMALE MALE SOCIAL SECURITY #			E ADDRESS AS CHILD?	es no
MAILING ADDRESS IF DIFFERENT		DDE	CITY	STATE
EMAIL PLACE OF EMPLOYMENT				
SAME PHONE # AS CHILD? YES NO PH	IONE # (IF DIFFERENT)			
SAME PHONE # AS CHILD? YES NO PH PRIMARY INSURANCE (required unless self-pay)	IONE # (IF DIFFERENT)		RY INSURANCE (optional)	
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME	INS	SECONDAR		
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID #	INS PC	SECONDAR SURANCE COMPANY N DLICY/ID #		
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID # GROUP #	INS PC	SECONDAR		
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID #	INS PC GF	SECONDAR SURANCE COMPANY N DLICY/ID #	JAME	
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID # GROUP #	INS PC GF PC	SECONDAR SURANCE COMPANY N DLICY/ID # ROUP # DLICY HOLDER'S NAME	JAME	HEIR INFO:
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID # GROUP # POLICY HOLDER'S NAME AS LISTED ON CARD	INS PC GF PC IR INFO: IF	SECONDAR SURANCE COMPANY N DLICY/ID # ROUP # DLICY HOLDER'S NAME	JAME AS LISTED ON CARD	HEIR INFO:
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID # GROUP # POLICY HOLDER'S NAME AS LISTED ON CARD IF POLICY HOLDER IS GRANDPARENT/STEP-PARENT, LIST THE	INS PC GF PC IR INFO: IF I FU	SECONDAR SURANCE COMPANY N DLICY/ID # ROUP # DLICY HOLDER'S NAME POLICY HOLDER IS GRA	JAME AS LISTED ON CARD	
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID # GROUP # POLICY HOLDER'S NAME AS LISTED ON CARD IF POLICY HOLDER IS GRANDPARENT/STEP-PARENT, LIST THE FULL NAME	IR INFO: IR MALE	SECONDAR SURANCE COMPANY N DLICY/ID # ROUP # DLICY HOLDER'S NAME POLICY HOLDER'S NAME	JAME AS LISTED ON CARD	
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID # GROUP # POLICY HOLDER'S NAME AS LISTED ON CARD IF POLICY HOLDER IS GRANDPARENT/STEP-PARENT, LIST THE FULL NAME DATE OF BIRTH	IR INFO: IR MALE	SECONDAR SURANCE COMPANY N DLICY/ID # ROUP # DLICY HOLDER'S NAME POLICY HOLDER'S NAME LL NAME ATE OF BIRTH	JAME AS LISTED ON CARD	
PRIMARY INSURANCE (required unless self-pay) INSURANCE COMPANY NAME POLICY/ID # GROUP # POLICY HOLDER'S NAME AS LISTED ON CARD IF POLICY HOLDER IS GRANDPARENT/STEP-PARENT, LIST THE FULL NAME DATE OF BIRTH SOCIAL SECURITY #	IR INFO: IR MALE AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	SECONDAR SURANCE COMPANY N DLICY/ID # ROUP # DLICY HOLDER'S NAME POLICY HOLDER'S NAME LL NAME ATE OF BIRTH DCIAL SECURITY #	JAME AS LISTED ON CARD	

You must list ALL health insurance policies and ask for additional pages if necessary. Please present insurance card(s) at ALL visits.