Cottonwood Pediatrics

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 ADDRESS

ZIP CODE CITY STATE MAILING ADDRESS IF DIFFERENT

SOCIAL SECURITY # MAIN PHONE # OTHER PHONE #

RACE ETHNICITY LANGUAGE

I DECLINE TO STATE MY CHILD'S RACE/ETHNICITY/LANGUAGE (PLEASE INITIAL)

PARENT INFORMATION

FULL NAME DOB (MM/DD/YYYY)

☐ FEMALE ☐ MALE SOCIAL SECURITY # SAME ADDRESS AS CHILD? ☐ YES ☐ NO

MAILING ADDRESS IF DIFFERENT ZIP CODE CITY STATE

EMAIL PLACE OF EMPLOYMENT

SAME PHONE # AS CHILD? ☐ YES ☐ NO PHONE # (IF DIFFERENT)

FULL NAME DOB (MM/DD/YYYY)

☐ FEMALE ☐ MALE SOCIAL SECURITY # SAME ADDRESS AS CHILD? ☐ YES ☐ NO

MAILING ADDRESS IF DIFFERENT ZIP CODE CITY STATE

EMAIL PLACE OF EMPLOYMENT

SAME PHONE # AS CHILD? ☐ YES ☐ NO PHONE # (IF DIFFERENT)

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 THEIR INFO:

FULL NAME

DATE OF BIRTH ☐ FEMALE ☐ MALE

SOCIAL SECURITY #

EMPLOYER

MAIN PHONE #

OTHER PHONE #

SECONDARY INSURANCE (optional)

INSURANCE COMPANY NAME

POLICY/ID #

GROUP #

POLICY HOLDER'S NAME AS LISTED ON CARD

IF POLICY HOLDER IS GRANDPARENT/STEP-PARENT, LIST THEIR INFO:

FULL NAME

DATE OF BIRTH ☐ FEMALE ☐ MALE

SOCIAL SECURITY #

EMPLOYER

MAIN PHONE #

OTHER PHONE #

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