Oklahoma Kids Pediatrics
Sara Buntin, APRN, CPNP

Oklahoma Kids Pediatrics
Patient Profile

PATIENT INFORMATION

Name:_____ Sex:_____
Last First Middle

Address:_____Date of Birth:_____
_____Race:_____

City, State:_____Language:_____
Email:_____Social Security #:_____
Phone:_____{ }Cell { }Work
Phone:_____{ }Cell { }Work
Phone:_____{ }Cell { }Work
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 Oklahoma Kids Pediatrics for any and all medical or surgical services rendered. I understand that if any of services or charges are not covered or if Oklahoma Kids Pediatrics 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 Parent or Guardian Date