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Claudia Sussdorf, M.D. • Jacinta White Topps, M.D. • Sita S. Canady, M.D.

Patient Name: _____ Sex: Male Female
Address: _____
City/County: _____ State: _____ Zip Code: _____
Date of Birth: _____ Language Preference _____
Any Allergies to Food/Medication? No Yes List: _____
Patient Phone Number (If Applicable): _____ Over 18? Yes No
Pharmacy Preference: _____ Pharmacy Phone Number: _____

Name of Parent/Guardian: _____ Date of Birth: _____
Relationship to Patient: Mother Father Legal Guardian Step-Parent
Address: Same as above if different: _____
City/County: _____ State: _____ Zip Code: _____
Primary Phone Number: _____ Secondary Number: _____
Employer's Name/Address: _____
City/County: _____ State: _____ Zip Code: _____
E-mail Address for Appointment Reminders: _____
Marital Status: Married Single Widowed Divorced Separated

Name of Parent/Guardian: _____ Date of Birth: _____
Relationship to Patient: Mother Father Legal Guardian Step-Parent
Address: Same as above if different: _____
City/County: _____ State: _____ Zip Code: _____
Primary Phone Number: _____ Secondary Number: _____
Employer's Name/Address: _____
City/County: _____ State: _____ Zip Code: _____
E-mail Address for Appointment Reminders: _____
Marital Status: Married Single Widowed Divorced Separated

Primary Insurance: _____	Secondary Insurance: _____
Policy ID: _____	Policy ID: _____
Group ID: _____	Group ID: _____
Policyholder Name: _____	Policyholder Name: _____
Policyholder SSN: _____	Policyholder SSN: _____
Policyholder DOB: _____	Policyholder DOB: _____

I understand that all financial responsibility, for any medical services provided to my child by Fall Hill Pediatrics, will be mine if it is determined that my insurance was not in effect on the date of service. I agree to pay all collection or attorney fees related to any medical services provided.

Parent/Legal Guardian/Patient Signature: _____ **Date:** _____