Pediatrics of Southwest Houston

Pediatrics of Southwest Houston

Patient Information (Please print and fully complete all information)

Patient Name: _____
First Name Middle Name Last Name

Home Address: _____ City: _____ State: _____ Zip Code: _____

Date Of Birth: _____ Age: _____ ☐ Male ☐ Female SSN: _____

Preferred Pharmacy Name and Phone #: _____

Cell Phone # : _____ Who referred you to this office: _____

Parents Information:

Mothers Name: _____ Fathers Name: _____

Date Of Birth: _____ Age: _____ Date Of Birth: _____ Age: _____

SSN: _____ SSN: _____

Drivers License: _____ Drivers License: _____

Employer: _____ Employer: _____

Occupation: _____ Occupation: _____

Cell Phone #: _____ Cell Phone #: _____

E-mail: _____ E-mail: _____

Emergency Contact (Who may we contact in case of an emergency other than the parents):

Name: _____ Phone Number: _____ Relationship: _____

Primary Insurance Company:

Insurance Company Name: _____ Phone Number: _____

Insured Party Name: _____ Insurance ID #: _____

Insurance Address: _____ City: _____ State: _____ Zip Code: _____

Secondary Insurance Company:

Insurance Company Name: _____ Phone Number: _____

Insured Party Name: _____ Insurance ID #: _____

Insurance Address: _____ City: _____ State: _____ Zip Code: _____

Please complete second page

I give permission for the following people to seek medical care, on my behalf, for the above listed child:

Name: First Name Middle Name Last Name

Address: City: State: Zip Code:

Phone Number: Relationship:

Name: First Name Middle Name Last Name

Address: City: State: Zip Code:

Phone Number: Relationship:

Name: First Name Middle Name Last Name

Address: City: State: Zip Code:

Phone Number: Relationship:

Only the following listed people will be permited to obtain information regarding my child:

Name: Relationship:

Name: Relationship:

Name: Relationship:

- I consent to treatment as necessary or desired for the above named patient, including but not restricted to whatever drugs, medicines, procedures, laboratory, X-Ray, or other studies that may be used by the attending Doctor or his/her qualified designate.

- I, also, acknowledge full responsibility for the payment of such services at the time of service unless other arrangements have been made. I understand that my insurance carrier is being billed as a courtesy to me, but should they not pay for these charges I understand that I will assume full financial responsibility.

- I authorize the release of any medical or other information necessary to process the insurance claim for services provided to my child.

- I also authorize any payment due from my medical insurance to be paid directly to Little Buddies Pediatrics PA. dba Pediatrics of Sugar Land

Signed: Date:

Save Form Print Form Send Form