

# Pediatrics Of Southwest Houston

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## 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:

Other children being seen at this office:

Phone Number:  Who referred you to this office:

## Patient Information

Mothers Name: <input type="text"/>	Fathers Name: <input type="text"/>
Date Of Birth: <input type="text"/> Age: <input type="text"/>	Date Of Birth: <input type="text"/> Age: <input type="text"/>
SSN: <input type="text"/>	SSN: <input type="text"/>
Drivers License: <input type="text"/>	Drivers License: <input type="text"/>
Employer: <input type="text"/>	Employer: <input type="text"/>
Occupation: <input type="text"/>	Occupation: <input type="text"/>
Work Phone: <input type="text"/> Ext. <input type="text"/>	Work Phone: <input type="text"/> Ext. <input type="text"/>
E-mail: <input type="text"/>	E-mail: <input type="text"/>

## 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 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.

Date:  Signature of Patient or Responsible Party:

***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 permitted to obtain information regarding my child**

Name:  Relationship:

Name:  Relationship:

Name:  Relationship:

- 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 Pediatrics of Southwest Houston.

- I give my consent to be part of the Pediatrics Of Southwest Houston appointment reminder call system.  Yes  No

Signed:  Date:

