EVERYTHING NEEDS TO BE FILLED OUT COMPLETELY

WELCOME TO NORTH AUSTIN PEDIATRICS, P.A.!

PATIENT'S LEGAL NAME: ____________________
last name first name middle name nickname

PATIENT'S DATE OF BIRTH: / / BIRTH HOSPITAL: ____________ SEX: M F

ADDRESS: ____________ CITY: ____________ ST: ____ ZIP: ____________

PRIMARY PHONE #: ____________ MOM'S CELL#: ____________ DAD'S CELL #: ____________

** May we leave lab result on your answering machine? Y / N Email:____________

MOTHER'S NAME: ____________ DATE OF BIRTH: / / **SSN**: ____________

MAIDEN NAME: ____________

ADDRESS (IF DIFFERENT): ____________

EMPLOYER: ____________ WORK #: ____________ **Driver's License** #: ____________

FATHER'S NAME: ____________ DATE OF BIRTH: / / **SSN**: ____________

ADDRESS (IF DIFFERENT): ____________

EMPLOYER: ____________ WORK #: ____________ **Driver's License** #: ____________

EMERGENCY CONTACT, other than parents:

Name: ____________ Relationship: ____________

Address: ____________ City: ____________ State: ____________ Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

MINORS: For patients not accompanied by a parent or legal guardian, written permission to treat the child is required before any treatment can be given. Please list those persons who you give permission to bring your child to the office for treatment: ____________

POLICY HOLDER & INSURANCE INFORMATION

INSURANCE CARRIER NAME: ____________ POLICY HOLDER EMPLOYER: ____________

NAME OF POLICY HOLDER: ____________ RELATIONSHIP TO PATIENT: ____________

ADDRESS OF POLICY HOLDER: ____________ CITY: ____________ ZIP: ____________

HOME PHONE #: ____________ CELL PHONE #: ____________ WORK PHONE #: ____________

DATE OF BIRTH: ____________ SSN #: ____________ DRIVER'S LIC. #: ____________

ASSIGNMENT OF BENEFTIS/CONSENT FOR TREATMENT

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT OF BENEFITS TO NORTH AUSTIN PEDIATRICS, PA, AND ANY ASSISTING PROVIDERS FOR SERVICES RENDERED IN THE MEDICAL CARE OF MY CHILD. I UNDERSTAND I (PARENT, AND OR GUARANTOR) AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT THEY ARE COVERED BY INSURANCE. I HEREBY AUTHORIZE THIS HEALTH CARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE PROPER MEDICAL CARE, AND PAYMENT OF INSURANCE BENEFITS. I FURTHER AGREE A COPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL. MEDICAL CARE MAY BE PROVIDED BY PEDIATRIC NURSE PRACTITIONERS AND OR ON CALL PHYSICIANS.

SIGNATURE: ____________ DATE: ____________

**** **HOW DID YOU HEAR ABOUT OUR PRACTICE**? ____________