North Texas Pediatrics

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Date Completed: _________________

CHILDREN:
NAME:_____________________ DATE OF BIRTH _____/_____/_____ SEX: ______
NAME:_____________________ DATE OF BIRTH _____/_____/_____ SEX: ______
NAME:_____________________ DATE OF BIRTH _____/_____/_____ SEX: ______
NAME:_____________________ DATE OF BIRTH _____/_____/_____ SEX: ______

Mother:
Name:__________________________
Address:________________________
City: _______ State:_____Zip:______
Home: (_____)___________________
Work Phone: : (_____)_____________
Cell Phone: : (_____)______________
Email: _________________________
Social Security #: ________________
Date of Birth: ___________________
Drivers License: _________________
Occupation:_____________________
Employer:______________________
Address:________________________
City: __________State:___Zip:______

Father:
Name:__________________________
Address:________________________
City: ______ State:______ Zip:_____
Home: (_____)___________________
Work Phone: : (_____)_____________
Cell Phone: : (_____)______________
Email: _________________________
Social Security #: ________________
Date of Birth: ___________________
Drivers License: _________________
Occupation:_____________________
Employer:_______________________
Address:________________________
City: ________ State:____ Zip:______

INSURANCE INFORMATION (We will need a copy of your card)
Insurance Company Name: ____
Name of Insured Person: __________________ID #:________________ Group#:______________
Emergency Contact: (Other than parent)
Name of contact not living with you:__________________________ Relationship: _____________
Home Phone: (_____)_____________ Work Phone: (_____)_____________

Assignment of Benefits:
I hereby authorize the release of any medical information necessary to process an insurance claim and assign payment to be made directly to North Texas Pediatrics. A photocopy of this agreement is to be considered as valid as an original. *I understand that I am financially responsible for all charges regardless of my insurance claims.*
Signature____ Date: ______________________

We reserve the right to charge for appointments canceled or broken without 24-hour advance notice.