EVERYTHING NEEDS TO BE FILLED OUT COMPLETELY
WELCOME TO NORTH AUSTIN PEDIATRICS, P.A.!

PLEASE PRINT

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

PATIENT'S DATE OF BIRTH: _____ BIRTH HOSPITAL: _____ SEX: M ◯ F ◯

PATIENT'S ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PRIMARY PHONE DAD ◯ MOM ◯ (circle one) **#:** _____

SECONDARY PHONE DAD ◯ MOM ◯ (circle one) **#:** _____

** May we leave lab result on your answering machine? Y ◯ N ◯ Email: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY ADDRESS: _____

MOTHER'S NAME: _____ DATE OF BIRTH: _____ **SSN**: _____

BABY'S NAME AS IT APPEARS IN HOSPITAL RECORD: _____ MOTHER'S MAIDEN NAME _____

ADDRESS (IF DIFFERENT): _____

EMPLOYER: _____ WORK #: _____

DAD ◯ MOM ◯ (circle one) NAME: _____ DATE OF BIRTH: _____ **SSN**: _____

ADDRESS (IF DIFFERENT): _____

EMPLOYER: _____ WORK #: _____

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 the office and make medical decisions on your behalf: _____

_____

EMERGENCY CONTACT, other than parents:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

POLICY HOLDER & INSURANCE INFORMATION

INSURANCE CARRIER NAME: _____ POLICY HOLDER EMPLOYER: _____

INSURED PARENT'S NAME: _____ RELATIONSHIP TO PATIENT: _____

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****IF POLICYHOLDER OF INSURANCE IS DIFFERENT THAN PARENT LISTED ABOVE, PLEASE COMPLETE THE FOLLOWING:**

ADDRESS OF POLICY HOLDER: _____ CITY: _____ ZIP: _____

HOME PHONE #: _____ CELL PHONE #: _____ WORK PHONE #: _____

DATE OF BIRTH: _____ SSN #: _____

ASSIGNMENT OF BENEFITS AND 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: _____