pediatric clinic mount pleasant

NEW PATIENT

PATIENT

First | Middle | Last

Nickname (if any)

Present Age

Date of Birth

Mailing Address

Social Security #

Male
Female

Primary Phone Number

Race: White Black / African American American Indian Asian Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Other or Undetermined

City / State /Zip

Preferred Language: English Spanish Other

PARENT/GUARDIAN

Mother's Name | Date of Birth | Primary Phone | Home Work Cell

Address (if different) | Social Security # | Driver's License# | Alternate Phone | Home Work Cell

Employer | Email Address

Father's Name | Date of Birth | Primary Phone | Home Work Cell

Address (if different) | Social Security # | Driver's License # | Alternate Phone | Home Work Cell

Employer | Email Address

Responsible Party (if parent under 18 years of age/Foster parent/Guardian) | Relationship | Date of Birth | Primary Phone | Home Work Cell

Address (if different) | Social Security # | Driver's License # | Alternate Phone | Home Work

Employer | Email Address

INSURANCE

Patient's Primary Insurance Company | Name of Insured Party | Insured Date of Birth | Insured Phone

Insured Party Social Security # | Insured ID # | Policy Group # | Relationship to patient

Patient's Secondary Insurance Company | Name of Insured Party | Insured Date of Birth | Insured Phone

Insured Party Social Security # | Insured ID # | Policy Group # | Relationship to patient

In accordance with Texas Law, The Pediatric Clinic will not provide health care to minors unless a parent accompanies them, a parent provides written consent, or a way is provided for the clinic to contact the parent. In Texas, patient is considered a "minor" is he/she is under 18 years, has never been married or has not been declared legally emancipated minor.

I authorize the following individuals to seek medical treatment for the child listed above, in my absence.

Non-Parental Contact

Name | Relationship | Phone

Name | Relationship | Phone

Name | Relationship | Phone

Name | Relationship | Phone

Signature of Responsible Party | Date

Update Signature | Date

Update Signature | Date

Update Signature | Date

2001 N. Jefferson Medical Office Building, Suite 300 Mt. Pleasant, Texas 75455 903-572-9823 FAX 903-572-4812

NEWBORNS ONLY

Date: _____

Print Patient Name: _____

Patient DOB: _____

It is my responsibility to provide Pediatric Clinic Mount Pleasant with current, valid insurance information. If I do not provide this information within timely filing deadlines, the balance will be my responsibility.

Print Responsible Party: _____

Signature Responsible Party: _____

Pediatric Clinic Mount Pleasant allows 30 days to apply/add to insurance. After this time, you will receive statements, by mail or MyChart, regarding your balance. You can contact us to set up payment arrangements.