



Pediatric Clinic, P.A.

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PATIENT	First	Middle	Last	Nickname (if any)	Present Age	Date of Birth		
	Mailing Address			Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Phone Number		
	City / State / Zip			Race: White Black / African American American Indian Asian Native Hawaiian/Pacific Islander		Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Other or Undetermined		
				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 Cell	
	Employer			Email Address				
	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 a legally emancipated minor.

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

NON-PARENTAL CONTACTS	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 _____



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NEWBORN FINANCIAL RESPONSIBILITY

Print Patient Name: _____

Patient DOB: _____

It is my responsibility to provide The Pediatric Clinic 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: _____

Date: _____

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