

Tejas Pediatrics Patient Registration Form

PLEASE PRINT:

PATIENT INFORMATION

Initial Appointment Date: ___/___/___
New Patient Established Patient/Update

Name: _____ Date of Birth: ___/___/___
LAST FIRST M.I.

Address: _____ Sex: M F

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ SS#: _____

Child lives with: Both parents Mother Father Other: _____

Parents are: Married Separated Divorced Who has custody: _____

Siblings: _____
(PLEASE LIST ALL SIBLINGS FIRST NAME, LAST NAME & DOB)

Pharmacy Name & Phone#: _____

CONTACT INFORMATION (Please list contact numbers in order of preference)

1. _____ Home Cell Work
NAME RELATIONSHIP NUMBER
2. _____ Home Cell Work
NAME RELATIONSHIP NUMBER
3. _____ Home Cell Work
NAME RELATIONSHIP NUMBER

PARENTS INFORMATION (Please give driver's license to receptionist)

Mother's Name: _____ Date of Birth: ___/___/___
LAST FIRST M.I.

Driver's License: _____ SS#: _____

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

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone#: _____

Father's Name: _____ Date of Birth: ___/___/___
LAST FIRST M.I.

Driver's License: _____ SS#: _____

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

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

INSURANCE INFORMATION (Please give insurance card(s) to receptionist)

Primary Insurance: _____

Policy #: _____ Group # _____

Policy Holder Name: _____ Date of Birth: ___/___/___
LAST FIRST M.I.

Relationship of patient to insured: _____

Secondary Insurance: Yes No Secondary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: ___/___/___
LAST FIRST M.I.

Relationship of patient to insured: _____

EMERGENCY CONTACT

Name: _____ Relationship _____

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

Home Phone #: _____ Cell Phone #: _____

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1. I certify to the best of my knowledge the above information is correct.
 2. I authorize Tejas Pediatrics to review my insurance coverage with my insurance company as indicated.
 3. I authorize Tejas Pediatrics to release medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered to the patient.
 4. The undersigned agrees that all services are rendered on a paid basis only. If payments are not received within 60 days of the visit, collection may become necessary. The undersigned shall pay all cost including attorney's fees, and/or collection fees.
 5. I hereby authorize you to pay directly to Tejas Pediatrics for benefits payable to me for services rendered.
 6. I authorize Tejas Pediatrics to release copies of my medical records to other medical providers whom I may be referred to for further patient care.
 7. I understand that Tejas Pediatrics encourages patients to receive all required immunizations as recommended by the American Academy of Pediatrics, Advisory Committee on Immunization Practices, Center for Disease Control and the State of Texas Department of Health.
 8. I understand that Tejas Pediatrics complies with all HIPAA regulations and that a copy of the complete HIPAA policy is posted in each waiting room and available upon request.
 9. I have read and agree to Tejas Pediatrics Financial Policy.
 10. I have read and understand Tejas Pediatrics' Required Immunization Schedule.

Signed: _____ Date: _____