LONE STAR PEDIATRICS
12120 RR 620
Austin, TX 78750
(512) 833-7334

PATIENT & INSURANCE INFORMATION

Today's Date: _____

Please list full legal name of child/patient

First: _____ Middle: _____ Last: _____

DOB: ____/____/_____ Age:_____ Sex: *M* *F*

Name Child Would Like to Be Called (if different from above): _____

Patient's Home Address: _____ City: _____ State: _____Zip: _____

Primary Phone: _____ May we leave a message on the voicemail? ☐ Yes ☐ No

Mother's Name: _____ DOB: ____/____/_____ SSN: _____

Address (if different from above): _____ Cell Phone: _____

Employer: _____Occupation:_____ Work Phone: _____

Father's Name: _____ DOB: ____/____/_____ SSN: _____

Address (if different from above): _____ Cell Phone: _____

Employer: _____Occupation:_____ Work Phone: _____

Would you like to be added to our mailing list? ☐ Yes ☐ No Email: _____

Did you attend our prenatal? ☐ Yes ☐ No

How did you hear about our practice?

☐Friend/Family ☐Insurance Company ☐Yelp ☐Google ☐Website ☐Drive By ☐MD Referral: _____ ☐Other:_____

WHO IS FINANCIALLY RESPONSIBLE?

This portion MUST be completed for proper billing and filing of insurance claims

Name: _____ Address (if different from patient): _____

Relation to Patient: _____SSN: _____-____-_____ DOB: _____ Phone Number: _____

Primary Insurance: _____ Claims Address: _____ Insurance Phone Number: _____

ID Number: _____ Group Number: _____

EMERGENCY CONTACT OTHER THAN PARENTS

Name: _____Relationship: _____

Address: _____ Phone: _____

The responsibility for payment and the presentation of active insurance card at the time of service is the responsibility of the accompanying parent or guardian.

ASSIGNMENT OF BENEFITS

IN THE EVENT THAT SERVICES RENDERED ARE NOT PAID FOR BY THE RESPONSIBLE PARTY, I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO **LONE STAR PEDIATRICS** AND ANY ASSISTING PROVIDERS FOR SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT THEY ARE COVERED BY INSURANCE. I HEREBY AUTHORIZE THIS HEALTHCARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS, I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE: _____ DATE: _____