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

INSURANCE INFORMATION

Patient Name: _____
Last Name First Name Middle Name

Patient's Date of Birth: _____ / _____ / _____ Age: _____ Sex: ☐ Female ☐ Male

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

Home Phone: (_____) _____ May we leave a message on your answering machine: ☐ Yes ☐ No

How did you hear about our practice? _____ Did you attend our prenatal? _____

Mother: _____ Date of Birth: _____ / _____ / _____ SSN: _____

Employer: _____ Occupation: _____ Work Phone: (_____) _____

Email: _____ Cell Phone: (_____) _____

Father: _____ Date of Birth: _____ / _____ / _____ SSN: _____

Employer: _____ Occupation: _____ Work Phone: (_____) _____

Email: _____ Cell Phone: (_____) _____

Would you like to be added to our mailing list? ☐ Yes ☐ No Today's Date: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ EFFECTIVE DATE: _____

CLAIMS ADDRESS: _____ INSURANCE PHONE: (_____) _____

NAME OF PERSON CARRYING THIS INSURANCE: _____ INSURED'S DATE OF BIRTH: _____ / _____ / _____

RELATIONSHIP TO PATIENT: _____ INSURANCE ID #: _____ GROUP: _____

EMERGENCY CONTACT OTHER THAN PARENTS

Name: _____ Relationship: _____

Address: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

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: _____