Children's Specialty Care Clinic of N.W. Houston

Patient Information

Full Name: _____ D.O.B.: _____ Age: _____ Sex: M ___ F ___

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Social Security Number: _____

Father's Name: _____ Occupation: _____ Employer: _____

Home Tele. #: _____ Work #: _____ Emergency #: _____

Mother's Name: _____ Occupation: _____ Employer: _____

Home Tele. #: _____ Work #: _____ Emergency #: _____

Emergency Contact: _____ **Relationship:** _____ **Telephone #** _____

How did you hear about the clinic?: _____

Insurance:

Self Pay: _____ Medicaid: _____ Private Insurance Name: _____

Assignment and Release:

I, the undersigned certify that (or my dependent) have insurance coverage with the above mentioned insurance company and assign directly to **Children's Specialty Care Clinic of N.W. Houston, P.A.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship | Date

First Time Visit

I, _____ give my permission as a
(Relationship to child)

Parent/Legal Guardian of the above named Children's Specialty Care Clinic of N.W. Houston to treat my child.

_____ _____ _____

Parents/Guardian Signature | Date | Telephone