Pediatric and Adolescent Center of Grand Prairie Arlington
2715 Osler Drive, Grand Prairie, Texas 75051

Chart #: ______________________

FAMILY INFORMATION 2010

(PLEASE COMPLETE BOTH SIDES)

Date: ________

PATIENT(S NAME	SEX	DOB	SOCIAL SECURITY #	Medicaid #(

Home Address: ____________________ Phone # ( ) __________
City ______________ State __________ Zip __________
E-mail address: ____________________
Primary Care Provider (Physician) ____________________

Father's Name:____________________ Date of Birth____________Social Security #____________
Father's Address:____________________Phone # ( )____________
Father's Employer:____________________Phone # ( )____________
Employer's Address:____________________

Mother's Name:____________________ Date of Birth____________Social Security #____________
Mother's Address:____________________Phone #( )____________
Mother's Employer:____________________Phone #( )____________
Employer's Address:____________________

Primary Health Insurance Co.:____________________Phone # ( )____________
Policy ID#____________________ Group #____________
Policy Holder____________________Relationship to patient____________

Secondary Health Insurance Co.:____________________Phone# ( )____________
Policy ID#____________________Group #____________
Policy Holder____________________ Relationship to patient____________

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In Case of Emergency Contact (other than parent)____________________
Relationship to Patient____________________Phone# (   )____________________
Patient Referred By____________________

AUTHORIZATION TO SEEK MEDICAL TREATMENT

The following individuals are hereby authorized to seek medical treatment for my child(ren) in my absence:
Name:____________________Relationship to Patient:____________________
Name:____________________Relationship to Patient:____________________

Signature of Parent/Guardian:____________________Date:____________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGN BENEFITS

I hereby authorize the release of any medical information to process an insurance claim and in the case of assigned benefits, do hereby authorize payment directly to the physician.

Signature of Parent/Guardian____________________Date:____________________

ASSUMPTION OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible to the doctor for all charges incurred on my account whether covered by my insurance company or not. These charges are to be paid at the time services are rendered unless submitted to an insurance company with whom Pediatric and Adolesce Center of Grand Prairie & Arlington(Dr. Epifania Caturay, et al) has a participating contract. I also understand that non-covered services under my insurance policy and outstanding balances become my full responsibility. In the event collections proceedings are instituted to enforce payment of fees due to Pediatric and Adolescent Center of Grand Prairie & Arlington (Dr. Epifania Caturay, et al), I/we, the undersigned agree to pay the additional sum of twenty-five percent (25%) of the principal due as attorney fees, plus all associated court fees.

Signature of Parent/Guardian:____________________Date:____________________

IT IS YOUR RESPONSIBILITY TO NOTIFY THIS OFFICE IMMEDIATELY OF ANY CHANGES TO THE ABOVE INFORMATION

I HAVE REVIEWED THE 2008 INFORMATIC
MY FAMILY'S PERSONAL AND INSURANCI
INFORMATION HAS NOT CHANGED.
Name____________________Date____
Relationship to Patient:____________________

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(if applicable)

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