LUV-N-CARE PEDIATRICS

11811 Fallbrook Dr., Suite B-2
HOUSTON, TEXAS 77065

Date_____

Name of Patient_____
Age_____ Date of Birth____/____/____ Sex : Female/Male
Address_____ City_____ State _____Zip_____
Home Phone #(____)_____ Social Security Number_____-_____-_____

Father's Name_____ Father's Date of Birth____/____/_____
Father's Phone # _____ Cell Phone # _____
Occupation_____ Social Security Number_____-_____-_____
Employer's Name & Address_____
E-Mail Address _____

Mother's Name_____ Mother's Date of Birth____/____/_____
Mother's Phone # _____ Cell Phone # _____
Occupation_____ Social Security Number_____-_____-_____
Employer's Name & Address_____
E-Mail Address _____

With whom may we share information about your account?
Name_____
Relationship_____ Phone #(____)_____
With whom may we share medical records?
Name_____
Relationship_____ Phone #(_____)_____

Referred by: ___Friend/Relative, if so Name_____: __Phone Book_____
Newspaper Ad: ___Billboard: ___Another physician, if so name_____Hospital: ___Other
_____

*****IN CASE OF AN EMERGENCY WHO MAY WE NOTIFY?*****

Name_____ Relationship to Patient_____
Address_____ City_____ State_____ Zip_____
Home Phone #(___)_____ Cell Phone # (___)_____ Work Phone #(___)_____Ext:___

******WHO IS RESPONSIBLE FOR PAYMENT******

Name_____Relationship to Patient_____
Address_____City_____State_____Zip_____
Home Phone #(___)_____ Cell Phone #(___)_____ Work Phone #(___)_____Ext:___
E-Mail _____
****Insurance Company:**_____Phone #(____)_____
Group #_____ID#_____Cardholder Name:_____
SS # _____DOB_____

Payment is expected at the time services are rendered unless previous arrangements have been made. As a courtesy our office will file insurance claims for the Physician's fees in the event of hospitalization
*I hereby authorize DIRECT PAYMENT TO LUV-N-CARE PEDIATRICS for surgical/medical benefits.
I also authorize LUV-N-CARE PEDIATRICS to release any information necessary in the course of my treatment required by the insurance company covering these procedures and I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for all amounts not covered by insurance.

I have received notice of this organization's privacy practices.

Date_____ Signature:_____