



LUV-N-CARE PEDIATRICS

11037 FM 1960 West, Suite B-2A
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 _____

Mother's Name _____ Mother's Date of Birth ____/____/____

Mother's Phone # _____ Cell Phone # _____

Occupation _____ Social Security Number _____ - _____ - _____

Employer's Name & 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: _____