LUV-N-CARE PEDIATRICS

11811 Fallbrook Dr., Suite B-2,
Houston, TX 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:____