



MEDICAL CENTER PEDIATRICS

PATIENT INFORMATION FORM

Today's Date: _____

Father's Full Name: _____ D/O/B: ____/____/____

Social Security #: _____ - _____ - _____ TX Driver's Lic. #: _____

Employer's Name: _____ Work Phone: _____ Ext: _____

Job Position: _____ Work Address: _____

Home Address: _____ Apt. #: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Mother's Full Name: _____ D/O/B: ____/____/____

Social Security #: _____ - _____ - _____ TX Driver's Lic. #: _____

Employer's Name: _____ Work Phone: _____ Ext: _____

Job Position: _____ Work Address: _____

Home Address: _____ Apt. #: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Marital Status (Circle One): MARRIED SINGLE WIDOWED SEPARATED DIVORCED

If presently divorced, which parent has legal custody: _____

Name of Close Relative or Friend (Circle One): RELATIVE FRIEND

Name: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Referred to our office by: _____

Which doctor do you wish to see on a regular basis? (circle one): RUENES CARDENAS GARZA

Children's Full Names (List All Children):

(Circle)

1. _____ D/O/B _____ F / M

2. _____ D/O/B _____ F / M

3. _____ D/O/B _____ F / M

4. _____ D/O/B _____ F / M

5. _____ D/O/B _____ F / M

PLEASE READ AND COMPLETE THIS SECTION.

Primary Ins. Co. Name: _____ Phone #: _____

Insured's Name: _____

D.O.B.: _____ Group # _____ Policy # _____

Secondary Ins. Co. Name: _____ Phone #: _____

Insured's Name: _____

D.O.B.: _____ Group # _____ Policy # _____

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required to process this claim, and for Quality Assurance checks made by insurance companies. I further authorize release of medical records from any hospital, school, or healthcare providers to Medical Center Pediatrics for Concurrence of care.

Office Policy: Payment of our services is due and must be paid in full by the parent or guardian that brings the child at the time of the visit and after our services are rendered. A \$35.00 processing fee will be charged for any check returned to us not paid.

Delinquent Accounts: It is your duty (Parent/Guardian) to pay for our services in full after our service has been rendered, regardless of lack of insurance/coordination of benefits, divorce proceedings or financial stress. Your failure to pay us for our services will result in us assessing you with collection costs, and if necessary with attorney fees and court costs. All past due accounts are reported to SARMA (or San Antonio Retail Merchants Association).

Signature: _____ **Date:** _____