Patient Registration Update

Patient 1_____Sex___Date of Birth_____

Patient 2_____Sex___Date of Birth_____

Patient 3_____Sex___Date of Birth_____

Please check all that apply:

Child(ren) live with ___Mother ___Father___Step-Mother___Step-Father___Other_____

Custodial Parent (where the child lives)

Last Name:_____ First Name:_____

Spouse (step-parent name):_____

Street Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Alternate Phone:_____

Employer:_____ Phone:_____ ext:_____

SS#_____ Email Address:_____

Other Parent

Last Name:_____ First Name:_____

Spouse (step-parent name):_____

Street Address (if different):_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Alternate Phone:_____

Employer:_____ Phone:_____ ext:_____

SS#_____ Email Address:_____

Emergency contact_____ Phone:_____

Authorization of Treatment and Assignment of Benefits

I authorize Pediatricians of Dallas, P.A., Dr. Joe Neely, Dr. James Watkins, Dr. Matthew Yaeger, Dr. Somer Curtis, Dr. Karen Halsell, Dr. Chafen Hart, and Dr. Hillary Lewis to treat my child. I further authorize payment directly to Pediatricians of Dallas, P.A. for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.

_____ _____

Date