# Patient Registration

Patient 1_____ Sex___ DOB_____
Patient 2 _____ Sex___ DOB _____
Patient 3 _____ Sex___ DOB _____
Patient 4 _____ Sex___ DOB _____

## Patient Insurance Information- Primary Insured / Custodial Parent

Last Name: _____ First Name: _____
DOB_____SS#_____DL#_____
Email: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Primary Phone: _____ Alt Phone: _____
Employer: _____ Phone: _____ Ext: _____
Insurance Company: _____ Ins Phone: _____
Policy#: _____ Group/Plan#: _____

## Other Parent

Last Name_____ First Name: _____
DOB_____SS#_____DL#_____
Email: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Primary Phone: _____ Alt Phone: _____
Employer: _____ Phone: _____ Ext: _____

Children live with: Mother Father Guardian Other: _____
How did you hear about us? _____
Previous Pediatrician: _____
Emergency Contact: _____ Phone: _____

## Authorization of Treatment and Assignment of Benefits

I authorize, Pediatricians of Dallas, P.A., to treat my child. I further authorize payment directly to Pediatricians of Dalals, 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 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.

Signature _____ Date _____