New Patient Registration

Patient 1_____ Sex___ Date of Birth_____
Patient 2_____ Sex___ Date of Birth_____
Patient 3_____ Sex___ Date of Birth_____

Patients Insurance Information-Primary Insured / Custodial Parent

Last Name:_____ First Name:_____
Date of Birth_____ SS#_____ DL#_____
Street Address:_____
City:_____ State:_____ ZIP:_____
Primary Phone:_____ Alternate Phone:_____
Employer:_____ Phone:_____ Ext:_____
Insurance Company:_____ Insurance Phone:_____
Policy#_____ Group/Plan #:_____

Other Parent / Non-Custodial Parent

Last Name:_____ First Name:_____
Date of Birth_____ SS#_____ DL#_____
Street Address:_____
City:_____ State:_____ ZIP:_____
Primary Phone:_____ Alternate Phone:_____
Employer:_____ Phone:_____ Ext:_____

Children live with: Mother Father Guardian Other: _____

How did you hear about us? _____

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.

_____ _____
Parent's Signature Date