LONE STAR PEDIATRICS

2021 Patient Demographic Form

Patient/Child Information

Child Name:_____ □ Male □ Female Date of Birth_____
Child Name:_____ □ Male □ Female Date of Birth_____
Child Name:_____ □ Male □ Female Date of Birth_____
Child Name:_____ □ Male □ Female Date of Birth_____

Parent 1: _____ Date of Birth: _____

Home Address: _____ City, State, Zip_____

Cell Phone : _____ Preferred Phone 2:_____

Email Address:_____

Parent 2:_____ Date of Birth: _____

Home Address:_____ City, State, Zip_____

Cell Phone 1: _____ Preferred Phone 2:_____

Email Address:_____

Primary Insurance Information

Primary Insurance: _____

Member ID: _____Group:_____

Subscriber Name: _____

Relationship to patient: _____

Subscriber DOB: _____

Secondary Insurance Information

Secondary Insurance: _____

Member ID: _____ Group: _____

Subscriber Name: _____

Relationship to patient: _____

Subscriber DOB: _____

Pharmacy Information

Name: _____

Phone: _____

Address: _____

Fax: _____

Emergency Contact

Name: _____

Relationship: _____

Cell phone: _____

Alt. Phone: _____

Messages (unless requested otherwise, we only leave our name/phone and general message regarding appointments)
OK to leave a detailed message at home/cell? □ YES □ NO Work? □ YES □ NO Email messages? □ YES □ NO

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Lone Star Pediatrics; I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent. By signing below, I certify that I have read and understand the HIPAA Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____

Parent/Guardian Signature Date

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CONSENT TO TREAT AND PRESCRIPTIONS POLICY

I hereby give permission for the following people to obtain medical care for my child, and to have access to my child's medical records (this could be adult relatives/babysitters/a nanny etc.):

(Name)	(Relationship)
(Name)	(Relationship)
(Name)	(Relationship)
(Name)	(Relationship)

Lone Star Pediatrics is committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our prescription request policy. In order to fill prescriptions in a timely manner, we need your assistance with the following:

1. Typically a child must be seen before a medication can be prescribed for the first time. Exceptions are at the physician's discretion only.
2. Please allow **7 DAYS** for a prescription to be filled after it is requested. With this in mind, please allow enough time for the provider to complete your request **BEFORE** your child's prescription runs out.

IMPORTANT: If your child is prescribed a medication and appears to be having a reaction to it, please call our office immediately. It is imperative that our providers are aware of any reactions that need to be documented and followed up on.

Parent/Guardian Signature	Date