LAKE LEWISVILLE PEDIATRICS, LLP

PATIENT REGISTRATION

** PLEASE COMPLETE ENTIRE FORM**

GENERAL INFORMATION

GUARANTOR: LAST NAME FIRST M.I.	TITLE (CIRCLE ONE) MR. MRS. MS.	
STREET ADDRESS:	CITY:	ST/ZIP:
HOME PHONE:	WK PHONE:	EXT.
MOBILE PHONE:		DL#:
DATE OF BIRTH:	EMPLOYER:	OCCUPATION:
EMAIL ADDRESS:		
MARITAL STATUS: (CIRCLE ONE) (M) (D) (S) (W) SPOUSE NAME:	WORK PHONE:	CELL PHONE:
**OTHER PARENT	LAST NAME	FIRST NAME MI
HOME PHONE:	STREET ADDRESS:	
MOBILE PHONE:	CITY:	ST/ZIP:
WORK PHONE:	SS#:	DATE OF BIRTH:

ALL CHILDREN THAT MAY VISIT OUR OFFICE :

PATIENTS NAME: LAST FIRST MI	D.O.B:	M/F	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B:	M/F	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B:	M/F	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B:	M/F	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B:	M/F	PCP SELECTED

INSURANCE INFORMATION :

PRIMARY INSURANCE CARRIER:	POLICY ID #:	GROUP #:
NAME OF INSURED IF DIFFERENT FROM GUARANTOR:		
OTHER PERSONS AUTHORIZED TO SEEK SICK CARE:	RELATIONSHIP TO PATIENT:	

CONSENT TO TREAT

I hereby authorize employees and agents of Lake Lewisville Pediatrics, LLP, including physician, and other employees and staff members, to render medical evaluations and care to the patient(s) listed above. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**