TRINITY PEDIATRICS, P.A.

6105 WINDCOM COURT, #100 PLANO, TX 75093 - PHONE: 972-473-9063 - FAX: 972-473-9059

Date ________________________________ Referred by____

Patient Last Name_______________________________ First Name ________________________ MI _______

Date of Birth ____________________________________ Gender (Male) __________ (Female) __________

Address ____

City _________________________________ State ________________________ Zip Code ________________

Telephone ________________________________ Email ____

Mother's Name _____________________________________ Last Name ________________________________

Date of Birth _________________________________ Driver License #________________________________

Address ____

City _________________________________ State ________________________ Zip Code ________________

Place of Employment ______________________________________ Occupation ________________________

Work Phone _______________________________________ Cell Phone ________________________________

Father's Name _____________________________________ Last Name ________________________________

Date of Birth _________________________________ Driver License # ________________________________

Address ____

City _________________________________ State ________________________ Zip Code ________________

Place of Employment ______________________________________ Occupation ________________________

Work Phone _______________________________________ Cell Phone ________________________________

Patient lives with: ____

List all children under age 18:

Name ________________________________ Gender: M / F Date of birth ___________________________

Name ________________________________ Gender: M / F Date of birth ___________________________

Name ________________________________ Gender: M / F Date of birth ___________________________

Name ________________________________ Gender: M / F Date of birth ___________________________

EMERGENCY CONTACT (**Must be Completed**) Not living with you:

Name ____ Relationship ______________________________

Address ____

City _________________________________ State ________________________ Zip Code ________________

Phone (s) ____

Explanation of Payment Policy

We accept cash, check, debit card payment and credit cards (Visa, MasterCard, Discover or American Express). Payment for services is due and payable at the time the services are rendered.

All payments on unmet deductibles and co-pays are due in full at the time of service. If outdated or invalid information has been given to our office, payment in full is the responsibility of the parent/guarantor.

All insurance benefits from claims filed by TRINITY PEDIATRICS, P.A. prior to payment in full are assigned to his practice. In the event the insurance is cancelled, the services provided are not covered, or covered only in part, the undersigned is responsible for full payment for services rendered.

I, the undersigned, realize that all medical charges incurred by my dependent child for services rendered by TRINITY PEDIATRICS, P.A. are my financial responsibility and all fees necessary to collect my account are payable by me. I also, agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the fee charged by the agency.

Signature ______________________________________ Patient's Name _________________________________

Date ______________________________

Authorization for Treatment

I authorize the Physicians of TRINITY PEDIATRICS, P.A., or anyone they designate, to treat (Patient's Name): __________________________________ as considered necessary in my absence.

Signature ____ Date _________________________________