WOODHILL PEDIATRIC ASSOCIATES
8335 WALNUT HILL LN. # 220 * DALLAS, TX 75231 * 214-696-0222

CHILD'S NAME _____ SEX _____ DATE OF BIRTH _____
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ADDRESS WHERE CHILD/CHILDREN RESIDE _____ APT _____
CITY _____ STATE _____ZIP CODE _____

FATHER'S NAME _____ HM PH (_____)_____
ADDRESS IF DIFFERENT FROM CHILD _____
FATHER'S BIRTHDAY _____ SOCIAL SECURITY # _____ DL # _____
EMPLOYER NAME & ADDRESS _____ WK PH (_____)_____
E-MAIL ADDRESS _____ CELL PH. # _____

MOTHER'S NAME _____ HM PH (_____)_____
ADDRESS IF DIFFERENT FROM CHILD _____
MOTHER'S BIRTHDAY _____ SOCIAL SECURITY # _____ DL # _____
EMPLOYER NAME & ADDRESS _____ WK PH (_____)_____
E-MAIL ADDRESS _____ CELL PH. # _____

RESPOSIBLE PARTY IF DIFFERENT THAN PARENT:
NAME & ADDRESS _____RELATIONSHIP TO CHILD_____
_____PHONE # _____
SOCIAL SECURITY # _____DL # _____
EMPLOYER NAME & ADDRESS _____ WK PH (_____)_____

EMERGENCY CONTACT: _____ PHONE (_____)_____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF INSURANCE COMPANY _____ HMO POS EPO PPO _____
NAME OF INSURED _____ DATE OF BIRTH_____
SOCIAL SECURITY NUMBER _____ GROUP/PLAN/POLICY NUMBER _____
CLAIMS MAILING ADDRESS _____ CITY _____STATE _____
ZIP _____ PHONE NUMBER TO VERIFY BENEFITS _____

REFERRED BY: _____ DR. - FAMILY - FRIEND - INS. PLAN - PHONE BOOK

ASSIGNMENT OF BENEFITS - I hereby authorize the release of any medical information necessary to process an insurance claim and assign payment to be made directly to WOODHILL PEDIATRIC ASSOCIATES.
A photo copy of this agreement is to be considered as valid as the original. ***I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE STATUS OF MY INSURANCE CLAIMS AND IN THE EVENT THAT ONE OF WOODHILL PEDIATRIC ASSOC. PHYSICIANS IN NOT DECLARED YOUR PCP - PRIMARY CARE PHYSICIAN, I AM AWARE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED,***

PATIENT / GUARDIAN SIGNATURE _____ DATE _____

TO: _____
(Prior doctor)
ADDRESS _____ CITY _____ STATE _____ ZIP _____
RELEASE INFORMATION - I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:
WOODHILL PEDIATRICS ASSOCIATES AT THE ABOVE ADDRESS.

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE:
Name of Parent/Guardian: _____ Work # _____ Employer _____
If I find I am unable to accompany my above child/young adult to an appointment, I hereby grant permission to the Providers at Woodhill Pediatric Associates, to examine and treat my child if and when he/she arrives at the office unaccompanied, or is accompanied by someone other than a parent or guardian.

_____
Signature of Parent/Guardian Date

PLEASE PROVIDE NAMES OF ALL PERSONS ALLOWED TO SEEK MEDICAL INFORMATION AND/OR TREATMENT REGARDING YOUR CHILD. (THIS APPLIES TO FAMILY, FRIENDS AND CARETAKERS).

_____

_____

_____

_____

_____
Signature of Parent/Guardian Date

I, _____, have read/received a copy of **Woodhill Pediatrics** Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian Date