Pediatrics Of Sugar Land

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Patient Information (Please print and fully complete all information)

Patient Name:

First Name Middle Name Last Name

Home Address: City: State: Zip Code:

Date Of Birth: Age: ☐ Male ☐ Female SSN:

Preferred Pharmacy Name and Phone #:

Cell Phone # : Who referred you to this office:

Parents Information:

Mothers Name:		Fathers Name:	
Date Of Birth:	Age:	Date Of Birth:	Age:
SSN:		SSN:	
Drivers License:		Drivers License:	
Employer:		Employer:	
Occupation:		Occupation:	
Cell Phone #:		Cell Phone #:	
E-mail:		E-mail:	

Emergency Contact (Who may we contact in case of an emergency other than the parents):

Name: Phone Number: Relationship:

Primary Insurance Company:

Insurance Company Name: Phone Number:

Insured Party Name: Insurance ID #:

Insurance Address: City: State: Zip Code:

Secondary Insurance Company:

Insurance Company Name: Phone Number:

Insured Party Name: Insurance ID #:

Insurance Address: City: State: Zip Code:

Please complete second page

I Consent to treatment as necessary or desired for the above named patient, including but not restricted to whatever drugs, medicines, procedures, laboratory, X-Ray, or other studies that may be used by the attending Doctor or his/her qualified designate.

I, also, acknowledge full responsibility for the payment of such services at the time of service unless other arrangements have been made. I understand that my insurance carrier is being billed as a courtesy to me, but should they not pay for these charges I understand that I will assume full financial responsibility.

Date: ________ Signature of Patient or Responsible Party: ________

I give permission for the following people to seek medical care, on my behalf, for the above listed child:

Name: ________
First Name Middle Name Last Name

Address: ________ City: ________ State: ____ Zip Code: ________

Phone Number: ________ Relationship: ________

Name: ________
First Name Middle Name Last Name

Address: ________ City: ________ State: ____ Zip Code: ________

Phone Number: ________ Relationship: ________

Name: ________
First Name Middle Name Last Name

Address: ________ City: ________ State: ____ Zip Code: ________

Phone Number: ________ Relationship: ________

Only the following listed people will be permited to obtain information regarding my child:

Name: ________ Relationship: ________

Name: ________ Relationship: ________

Name: ________ Relationship: ________

- I authorize the release of any medical or other information necessary to process the insurance claim for services provided to my child.
- I also authorize any payment due from my medical insurance to be paid directly to Little Buddies Pediatrics PA. dba Pediatrics of Sugar Land

Signed: ________ Date: ________