

Pediatrics of Sugar Land

Robert C. Mao, M.D. - Laura M. Burgos-Orta, M.D.



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: <input type="text"/>	Fathers Name: <input type="text"/>
Date Of Birth: <input type="text"/> Age: <input type="text"/>	Date Of Birth: <input type="text"/> Age: <input type="text"/>
SSN: <input type="text"/>	SSN: <input type="text"/>
Drivers License: <input type="text"/>	Drivers License: <input type="text"/>
Employer: <input type="text"/>	Employer: <input type="text"/>
Occupation: <input type="text"/>	Occupation: <input type="text"/>
Cell Phone #: <input type="text"/>	Cell Phone #: <input type="text"/>
E-mail: <input type="text"/>	E-mail: <input type="text"/>

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 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 permitted to obtain information regarding my child:

Name: Relationship:

Name: Relationship:

Name: Relationship:

- 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.

- 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: