7103 South Peek Road
Unit E500
Richmond
Texas 77407

PATIENT'S LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ GENDER M / F RACE/ETHNICITY _____

MAILING ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP CODE _____ PRIMARY PHONE _____

FATHER'S NAME _____ DATE OF BIRTH _____

HOME/CELL _____ WORK PHONE _____

MOTHER'S NAME _____ DATE OF BIRTH _____

HOME/CELL _____ WORK PHONE _____

EMAIL ADDRESS _____

EMERGENCY CONTACT (Nearest Relative/Friend not living with Parent):

NAME _____ PHONE _____

RELATIONSHIP TO PATIENT _____

PHARMACY _____ PHONE _____

ADDRESS _____

INSURANCE INFORMATION: PLEASE PROVIDE COPY OF INSURANCE CARD(S)

INSURANCE COMPANY _____ INSURANCE PHONE NUMBER _____

POLICY OWNER/SUBSCRIBER NAME _____ DATE OF BIRTH _____

POLICY ID _____ GROUP # _____

DO YOU HAVE SECONDARY INSURANCE? YES or NO (circle one)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO LEGACY PEDIATRICS OF ALL MEDICAL BENEFITS, IF ANY, FOR THEIR SERVICES PROVIDED FOR MY CHILD WHICH YOUR OFFICE MAY FILE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION. ALL OFFICE VISITS AND SERVICES ARE DUE AND PAYABLE AT TIME OF SERVICE, UNLESS, OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR VISIT. I UNDERSTAND THAT ALL CONTRACTED INSURANCE CLAIMS WILL BE FILED, BUT THE GUARANTOR IS ULTIMATELY RESPONSIBLE FOR ALL FEES INCURRED.

SIGNATURE _____ DATE _____

PARENT OR LEGAL GUARDIAN