

Pediatric & Adolescent Specialists of Rockwall

Patient Information

First Name _____ Middle Initial _____ Last Name _____ Gender: M / F

Address _____ Apt # _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ SS# _____ Home # _____ Cell/Alt # _____

If patient is over 18 and covered on a parent or guardian's insurance, is the patient a full-time student? Yes No

If Patient is a Minor

Name of parent or legal guardian: _____ Relationship to Patient _____

Parent/Legal Guardian: Home phone _____ Work phone _____ Cell _____

Marital Status: S M D W Other _____ Date of Birth ____/____/____ SS# _____ DL# _____

Employer Name _____ Email Address _____

Name of spouse _____ Work number _____ Cell number _____

Date of Birth ____/____/____ SS# _____ Employer Name _____

Primary Insurance Information

Name of Insurance Co. _____ ID# _____ Group # _____

Policy Holders Name _____ **Patient's relationship to Insured** self spouse child other

Insured Date of Birth ____/____/____ Insured SS# _____ Employer Name _____

Secondary Insurance Information

Name of Insurance Co. _____ ID# _____ Group# _____

Policy Holders Name _____ **Patient's relationship to Insured** self spouse child other

Insured Date of Birth ____/____/____ Insured SS# _____ Employer Name _____

Emergency Contact (other than yourself or spouse)

Name _____ Relationship _____ Daytime phone _____

Pharmacy Name, Address & Phone Number _____

How did you hear about us? (circle one) Existing Patient Family Friend Office Website Insurance Company

Physician Referral Hospital Drive By Daycare Facility Childbirth Class Internet Site Other: _____

The above information is true and accurate. _____

Signature of Patient or legal guardian

Date