Heart of Texas Pediatrics

405 Londonderry Suite 201 Waco, TX 76712 (254) 399-8364

PATIENT REGISTRATION FORM

Patient Information

Patient Last Name:	First Name:	MI:	Today's Date:
Date of Birth:	Patient SSN#:	Home Phone#:	
Home Street Address:	City:	State:	Zip:
Previous Doctor:	Preferred Pharmacy:	Pharmacy Phone:	

Policy Holder

Last Name:	First Name:	MI:	Relationship to Patient:
Date of Birth:	SSN#:	Home Phone #:	Cell Phone #:
Work Phone:	Ext:		
Home Street Address (if different from patient)	City:	State:	Zip:

Insurance Plan

Primary Insurance Company:	Group#:	Policy#:	
Co-payment:	Effective Date:	Expiration Date:	
Employer:	Employer Address:	Secondary Insurance Plan:	ID#:

Authorization

I authorize the release of any medical information necessary to process insurance claims and the release of information back to my physician. I also authorize payment of medical benefits to Heart of Texas Pediatrics for services rendered. In the event that my medical insurance does not pay for the services rendered, I agree to pay Heart of Texas Pediatrics the usual and customary fees for these services. I acknowledge receipt of Notice of Privacy Practices (HIPPA).

Signed: _____ Date: _____

P.S. How did you hear about us?