San Antonio A thru Z Pediatrics, P.A.
1314 E. Sonterra Blvd., Ste. 5102, San Antonio, TX
210-490-8888; 210-496-6865 (fax)

7922 Ewing Halsell, Ste. 360, San Antonio, TX
210-614-7500; 210-614-7540 (fax)

Web: www.a-zpeds.com

New Patients

Patient's Name: _____ Gender: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

*Race: _____ *Ethnicity: _____ *Preferred Language: _____

Patient's Mother

Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Address (if different from above): _____

Employer: _____ Work Phone: _____

Email Address: _____

Patient's Father

Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Address (if different from above): _____

Employer: _____ Work Phone: _____

Email Address: _____

*Requirement under the Healthcare Reform Act

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Other Adult Family [Step Parents, Grandparents] (if applicable)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address (if different from above): _____

Employer: _____ Work Phone: _____

Email Address: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address (if different from above): _____

Employer: _____ Work Phone: _____

Email Address: _____

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Insurance

Primary Subscriber Name: _____

Subscribers Date of Birth: _____ Subscribers SSN: _____

Employer: _____

Policy #: _____ Group #: _____ Carrier: _____

Secondary Subscriber's Name: _____

Policy #: _____ Group #: _____ Carrier: _____

Pharmacy

Preferred Pharmacy: _____

Address (or cross streets): _____

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Payment & Treatment Agreement

1. I acknowledge that payment is due that time of service and that charges may vary according to the type and extent of services provided. I understand that I am financially responsible for all services rendered, regardless of insurance coverage. I hereby authorize for payment of benefits directly to San Antonio A Thru Z Pediatrics, P.A. for services rendered, for release of any information necessary to process claims, and for use of this signature on all insurance submissions. An electronic or photo copy of this document is considered valid as the original.

   Signature: _____ Date: _____

2. I hereby authorize the providers at San Antonio A Thru Z Pediatrics, P.A. to perform procedures (including suturing), and administer such treatment and medications as deemed necessary for the best care of the patient.

Signature: _____ Date: _____