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

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

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: ____

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

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): ____

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

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 preform procedures (including suturing), and administer such treatment and medications as deemed necessary for the best care of the patient.

Signature: ____ Date: _____________________