HOUSTON AREA PEDIATRIC NEUROLOGY, PLLC
INSURANCE INFORMATION

PATIENT INFORMATION:

Child's Full Name _____

Date of Birth _____ Age _____ Male / Female

Address _____

Home Phone Number _____

PARENT/GUARDIAN INFORMATION:

Name _____ Releationship to patient_____

Date of Birth _____ Work Phone_____

Address_____ Mobile/Pager_____

City,State,Zip_____ Driver's License#_____

RESPONSIBLE PARTY (INSURANCE INFORMATION):

Insurance Company _____ Phone Number _____

Address _____

Policy# _____ Group # _____

Insured's Name _____ Relationship to Patient:_____

Insured's Employer _____ Phone Number _____

Employer Address_____

Insured's Social Security # _____ Date of Birth _____ Male / Female

EMERGENCY CONTACT: Name of nearest relative/friend (not living with child)

Name: _____Home#_____Cell#_____

I hereby assign, transfer, and set over to Houston Area Pediatric Neurology, PLLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____