Kangos Pediatrics

12411 Hymeadow Drive, Suite 3F, Austin, TX 78750 Phone: (512) 250-1997 Fax: (512) 250-1529

PATIENT INFORMATION FORM

PATIENT NAME_____ RACE: _____ ETHNICITY: _____
FIRST MI LAST
STREET ADDRESS: _____ DATE OF BIRTH: ____/____/_____ AGE: _____
CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____ SEX: M F
HOME PHONE: (_____) _____-_____ SCHOOL: _____ SOCIAL SECURITY #:_____
MAILING ADDRESS IF DIFFERENT: _____

SIBLINGS:
NAME: _____ DOB: _____NAME: _____ DOB: _____
NAME: _____ DOB: _____NAME: _____ DOB: _____

RESPONSIBLE PARTY

NAME OF PARENT/GUARDIAN ACCOMPANYING CHILD: _____
ADDRESS: _____ SOCIAL SECURITY#: _____
CITY: _____ ST: _____ ZIP: _____ RELATIONSHIP TO PATIENT: _____
COUNTY:_____ DATE OF BIRTH: _____/_____/_____ SEX: M F
HOME PHONE: (_____) _____-_____ OCCUPATION: _____
WORK PHONE: (_____) _____-_____ EMPLOYER: _____
MOBILE PHONE: (_____) _____-_____ EMPLOYMENT STATUS: _____
EMAIL: _____ BEST WAY TO CONTACT: _____

OTHER PARENT/GUARDIAN: _____
ADDRESS: _____ SOCIAL SECURITY#: _____
CITY: _____ ST: _____ ZIP: _____ RELATIONSHIP TO PATIENT: _____
COUNTY:_____ DATE OF BIRTH: _____/_____/_____ SEX: M F
HOME PHONE: (_____) _____-_____ OCCUPATION: _____
WORK PHONE: (_____) _____-_____ EMPLOYER: _____
MOBILE PHONE: (_____) _____-_____ EMPLOYMENT STATUS: _____
EMAIL: _____ BEST WAY TO CONTACT: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____ SUBSCRIBER'S NAME: _____
DATE OF BIRTH: _____/_____/_____ RELATIONSHIP TO PATIENT: _____ SUBSCRIBERS ID #:_____
GROUP #: _____GROUP NAME/EMPLOYER: _____
SUBSCRIBER'S ADDRESS:_____CITY/STATE/ZIP_____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME: _____ SUBSCRIBER'S NAME: _____
DATE OF BIRTH: _____/_____/_____ RELATIONSHIP TO PATIENT: _____ SUBSCRIBERS ID #:_____
GROUP #: _____GROUP NAME/EMPLOYER: _____
SUBSCRIBER'S ADDRESS:_____CITY/STATE/ZIP_____

PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN PARENTS)

NAME:_____ PHONE: (_____) _____- _____
RELATIONSHIP TO PATIENT: _____

PHARMACY NAME/LOCATION: _____ PHONE: (_____) _____- _____

CONSENT TO TREAT:

I, HEREBY AUTHORIZE MY CHILD TO BE EVALUATED AND/OR TREATED BY THE PROVIDERS OF KANGOS PEDIATRICS.

SIGNATURE PARENT/GUARDIAN: _____DATE: _____/_____/_____