Martin Garza, M.D. P.A. - Patient Registration

Name of Pediatrician, Hospital, city where child was born: _____

Patient Name: _____
Last First Middle Suffix

DOB:___/___/___ Gender:____ Ethnicity: Hispanic___ or Non Hispanic___ SS#: ____-____-____ Home Ph.(____)-_____-_____
MM DD YY

Address: _____ _____ _____ _____
Mailing Zip Code City State

Father/Guardian

Name: _____
Prefix Last First Middle Suffix

DOB: _____/_____/_____ Marital Status: _____ SS#: _____-____-_____
MM DD YY

Address: _____ _____ _____ _____
Mailing Zip Code City State

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell (_____) _____-_____

Employer: _____ Occupation _____

Mother/Guardian

Name: _____
Prefix Last First Middle Suffix

DOB: _____/_____/_____ Marital Status: _____ SS#: _____-____-_____
MM DD YY

Address: _____ _____ _____ _____
Mailing Zip Code City State

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell (_____) _____-_____

Employer: _____ Occupation _____

Additional Children

☐ **Name**: _____ **DOB:** _____/_____/_____
Last First Middle MM DD YY

☐ **Name**: _____ **DOB:** _____/_____/_____
Last First Middle MM DD YY

☐ **Name**: _____ **DOB:** _____/_____/_____
Last First Middle MM DD YY

In case of Emergency Notify: _____ **Phone** (_____) _____-_____ **Relationship** _____

Although it is not anticipated, the administration of immunizations, medication or other treatment may result in adverse reaction to your child. For this reason, your authorization to administer is required. At your direction, however, we will allow another designated person to authorize treatment for your child if you indicate below.

In case of my absence, I authorize _____to bring in my child for appointments, medical treatments, administration of immunizations, medication or other treatment. The person designated above has knowledge of all known allergies, sensitivities, current medications that my child may not take and examinations and procedures that may be performed.

It is very important on each visit that you present your current insurance card. Please consult with receptionist on which insurance carriers we accept. Our office will make every attempt possible to file your visits correctly. Please let us know as soon as possible if your insurance has changed. A statement will be sent to you if there is a balance that was not covered by your carrier.

If you have no insurance coverage or if your insurance is not listed as one of the companyôs that we file for, all professional services rendered are charged to the patient. You are required to pay services rendered all the time of the visit. Unless other arrangements have been made. The guarantor will be given the necessary forms at the time of the office visit to expedite your forms. We do not wait for payment from your insurance company if you fail to keep your agreement to pay, your account may possibly be forwarded to a collection agency.

In case of hospital treatment, I authorize payment of medical benefits to undersign physician or supplier for services.
I understand and agree if my insurance does not cover or if I have no coverage, I will be responsible for the charges included. I certify this information is true and correct to the best of my knowledge.

X_____ _____/____/_____
Parent/Legal Guardian Signature **Date**

Referred by: _____

Martin Garza M.D. P.A.
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