

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

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

Patient Name: _____

DOB: ____/____/____ Gender: ____ Ethnicity: Hispanic ____ or Non Hispanic ____ Last 4 SS #: _____ Home Ph.(____)-____-____
MM DD YY

Address: _____
Mailing Zip Code City State

Father/Guardian

Name: _____

DOB: ____/____/____ Marital Status: _____ Last 4 SS #: _____
Prefix Last First Middle Suffix
MM DD YY

Address: _____
Mailing Zip Code City State

Home Phone (____) ____-____ Work Phone (____) ____-____ Cell (____) ____-____

Employer: _____ Occupation _____

Mother/Guardian

Name: _____

DOB: ____/____/____ Marital Status: _____ Last 4 SS #: _____
Prefix Last First Middle Suffix
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. The person designated is not authorized to take patient records without written parental consent.

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 company's 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. The guarantor will be given the necessary forms at the time of the office visit to expedite your forms. 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.

As of August 7, 2017 Martin Garza MD PA (DLC Pediatrics) will no longer accept new patients whose parents/guardians will not permit vaccination.

X _____
Parent/Legal Guardian Signature

____/____/____
Date

Referred by: _____