

CHILD NEUROLOGY & STROKE OF HOUSTON, PLLC

INSURANCE INFORMATION

PATIENT INFORMATION:

Patient's Full Name _____

Date of Birth _____ Age _____ Male / Female

Address _____

Home Phone Number _____

PARENT/GUARDIAN INFORMATION:

Name _____ Relationship to patient _____

Date of Birth _____

Address _____

City,State,Zip _____

Work Phone _____

Mobile/Pager _____

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 CHILD NEUROLOGY & STROKE OF HOUSTON, 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 _____