TEXAS ALLERGY

Medical Center • Northwest Houston • Southwest Houston
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MINOR INFORMATION:

Patient Name:_____Age:_____Birth Date:_____Sex: M F

Address:_____City: _____St._____Zip Code:_____

Home Phone:_____School Attending:_____Social Security#:_____

PARENT/GUARDIAN INFORMATION:

Mother:_____SS#_____Cell Phone:_____

Address(If different):_____Home phone :_____Email: _____

Employer:_____Occupation:_____Work phone:_____

Father:_____SS#_____Cell Phone:_____

Address(If different):_____Home phone:_____Email: _____

Employer:_____Occupation:_____Work phone:_____

PRIMARY INSURANCE INFORMATION: Is this a Workers Compensation Insurance? ( ) YES ( ) NO

Insurance Co:_____Phone :_____

Mailing Address:_____

Name of Insured:_____Birth Date:_____Relationship to Patient:_____

Policy #_____Group#_____Employer:_____

Secondary Insurance Information: Do you have other insurance coverage? ( )YES ( ) NO

Insurance Co:_____Phone :_____

Mailing Address:_____

Name of Insured:_____Birth Date:_____Relationship to Patient:_____

Policy #_____Group#_____Employer:_____

Other Misc. information:

Referred by: * Doctor( ) *Family ( ) *Friend ( ) Phone Book ( ) Insurance Book ( ) Other ( )_____

*Please give name & address:_____

Family Physician (PCP)_____Phone:_____

Do you have other family members who are patients in our office?_____Relationship_____

FINANCIAL RESPONSIBILITY, ASSIGMENT OF BENEFITS, AND RELEASE OF PROTECTED HEALTH INFORMATION

- I herby agree to pay Texas Allergy | Texas Allergy Group, PLLC for all charges (to include co-pays, deductible and co-insurance amounts) at the time of service. I understand that although the office may accept assignment of insurance benefits, the charges ultimately are my responsibility. I realize that if a balance is due necessitating the use of a collection agency, I agree to pay all collection costs, including attorney fees.
- I authorize Texas Allergy | Texas Allergy Group, PLLC to file insurance claims on my behalf to the company (ies) with which I have coverage to include the Social Security Administration. I authorize payment to be made to Texas Allergry Group for services rendered to me.
- I consent to the release of protected health information which may be necessary to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.
- I acknowledge that I have received a copy of Texas Allergy | Texas Allergy Group, PLLC Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices.
- I certify that I: **(Print Name)**_____ am the parent or legal guardian of the above named minor.

Parent/Guardian signature:_____**Date:**_____