

# PEDIATRIC SURGICAL ASSOCIATES OF FORT WORTH, P.A.

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## Patient Information

PATIENT NAME (First, Middle Initial, Last Name)	DATE OF BIRTH	AGE	PRIMARY PHONE	SECONDARY NO. (WORK/CELL)
ADDRESS	SOCIAL SECURITY NUMBER			
CITY, STATE, ZIP	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> OTHER	
REFERRING DOCTOR NAME & ADDRESS & PHONE	HOW DID YOU HEAR ABOUT US?			
PRIMARY CARE DOCTOR NAME & ADDRESS & PHONE				

## Person Bringing in Patient {Please Circle}: Mother, Father, Legal Guardian, Other

RESPONSIBLE PARTY NAME (First, Middle Initial, Last Name)	PRIMARY PHONE	SECONDARY PHONE (WORK/CELL)
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	EMAIL ADDRESS	PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY
EMPLOYER NAME & ADDRESS		

## Primary Insurance

WHO IS THE PRIMARY INSURED PARTY {Check One}  
 Patient (same as above)  Responsible Party (same as above)  Other (complete below)

PRIMARY INSURANCE COMPANY	Specialty Copay Amount	INSURED'S NAME (First, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP			
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DOB	PRIMARY PHONE	SECONDARY NO. (WORK/CELL)	
INSURANCE COMPANY PHONE NUMBERS	SOC. SEC. NO.	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	INSURED'S RELATIONSHIP TO PT.	
INSURED'S POLICY NUMBER	GROUP NUMBER #	INSURED'S EMPLOYER		LAB CORP / QUEST

## Secondary Insurance

WHO IS THE PRIMARY INSURED PARTY {Check One}  
 Patient (same as above)  Responsible Party (same as above)  Other (complete below)

SECONDARY INSURANCE COMPANY	Specialty Copay Amount	INSURED'S NAME (First, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP			
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DOB	PRIMARY PHONE	SECONDARY NO. (WORK/CELL)	
INSURANCE COMPANY PHONE NUMBERS	SOC. SEC. NO.	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	INSURED'S RELATIONSHIP TO PT.	
INSURED'S POLICY NUMBER	GROUP NUMBER #	INSURED'S EMPLOYER		LAB CORP / QUEST

## Other Parent/Legal Guardian Information (Mother, Father, Other)

NAME (First, Middle Initial, Last Name)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS (If different than above)	PRIMARY PHONE	SECONDARY NO. (WORK/CELL)
CITY, STATE, ZIP	EMAIL ADDRESS	
EMPLOYER NAME & ADDRESS		

## EMERGENCY CONTACT (Other than Parent)

EMERGENCY CONTACT (Other than Parent)	RELATIONSHIP TO PATIENT	CONTACT NUMBER
EMERGENCY CONTACT (Other than Parent)	RELATIONSHIP TO PATIENT	CONTACT NUMBER

## Authorization and Acknowledgement

I authorize the release of Medical Information necessary to process any insurance claim filed on behalf of my child. Also, I authorize the release of Medical Information to Referring Physician or Health Care Providers. I further authorize payment of Medical Benefits to Pediatric Surgical Associates of Fort Worth and understand ultimately that all balances are my responsibility.

**I understand that Pediatric Surgical Associates of Fort Worth requires the payment of all deductibles, coinsurance percentages, or surgery deposits TWO (2) working days before scheduled surgery. Failure to receive these payments by the appropriate time will result in cancellation of the surgery.**

\_\_\_\_\_  
Signature of Patient /Parent / Guardian / Insured

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Signature