AUSTIN
1301 Barbara Jordan Blvd., Suite 302
Austin, TX 78723

CEDAR PARK
1301 Medical Pkwy, Suite 310
Cedar Park, TX 78613

PHONE: 512-472-6134
FAX: 512-472-2928
childrensurology.com

pediatrix
UROLOGY OF CENTRAL TEXAS

Patient Information

Patient

Last Name: * _____ First Name: * _____ Nickname: _____

Date of Birth: * _____ Patient SSN: _____ Gender: * Male ____ Female ____ Non-binary ____

Race: American Indian or Alaskan Native ___ Asian ___ Black or African American ___ Native Hawaiian or other Pacific Islander ___ White ___

Other: _____ Decline: ____

Ethnicity: Hispanic/Latin ___ Not Hispanic/Latin ___ Other: _____ Decline: ____

Who referred you? (Please CHECK one) FAMILY ___ FRIEND ___ PHYSICIAN REFERRAL ___ WEBSITE ___

Person referring you: _____ Primary Care Doctor: * _____ Phone: * _____

In case a parent is not able to accompany the child, please list names of individuals you are allowing to accompany and make possible medical decisions for the minor patient.

NAME: * _____ **RELATIONSHIP: *** _____

NAME: _____ **RELATIONSHIP:** _____

Parent 1

Last Name: * _____ First Name: * _____ DOB: * _____ Social Security #: * _____

Street Address:* _____ City: * _____ State: * ____ Zip: * _____

Cell Phone: * _____ Secondary Phone: * _____ Email: * _____

*Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Parent 2

Last Name: _____ First Name _____ DOB: _____ Social Security #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Secondary Phone: _____ Email: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Emergency Contact

Last Name: * _____ First Name: * _____ Relation: * _____

Cell Phone: * _____ Secondary Phone: * _____

Primary Insurance

Policy Holder

Last Name: * _____ First Name: * _____ Policy Holder's Birth Date: * _____

Insurance Provider: * _____ Insurance ID Number: * _____ Group Number: * _____

Provider Phone Number (from insurance card): * _____ Policy Holder's SSN: * _____ Relation to Patient: * _____

Secondary Insurance

Policy Holder

Last Name: _____ First Name: _____ Policy Holder's Birth Date: _____

Insurance Provider: _____ Insurance ID Number: _____ Group Number: _____

Provider Phone Number (from insurance card): _____ Policy Holder's SSN: _____ Relation to Patient: _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER(S) - (Check <u>all</u> that apply)

___ **HOME TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **WORK TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **MOBILE TELEPHONE**
- ___ OK to leave message with detailed information
- ___ Leave message with call-back number only

___ **WRITTEN COMMUNICATION**
- ___ OK to mail to home address

___ **PATIENT PORTAL**

Email: * _____

PLEASE INITIAL

*____ I acknowledge I have reviewed the HIPAA Notice of Privacy Practices policy at childrensurology.com.

I hereby give authorization for payment of insurance benefits to be made directly to Pediatrix Urology of Central Texasfor services rendered.
<u>I understand that I am financially responsible for all charges whether or not they are covered by insurance</u>.

In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is valid as the original.

Name of Patient: * _____

Signature of Patient (or responsible party if a minor): * _____ Date: * _____