# NEW PATIENT FORM – PEDIATRIC SERVICES

**International Services**
Telephone: 832-824-1138
Fax: 832-825-2545

## PATIENT INFORMATION

| Last Name: | First Name: | Middle Initial: | Date of Birth (MM/DD/YY): | Gender (M/F): | Religion: |
|---|---|---|---|---|---|
| | | | | | |

## PERMANENT ADDRESS

| Street Address: | City: | State: | Zip Code: | Country: |
|---|---|---|---|---|
| | | | | |

## TEMPORARY ADDRESS

| Street Address: | City: | State: | Zip Code: | Country: |
|---|---|---|---|---|
| | | | | |

## ADDITIONAL INFORMATION

| Patient Language: | Interpreter Required:  ☐ Yes    ☐ No |
|---|---|
| Additional Information: | |

## PARENT/LEGAL GUARDIAN INFORMATION

| Last Name: | First Name: | Middle Initial: | Date of Birth (MM/DD/YY): | Relationship to Patient: |
|---|---|---|---|---|
| E-mail: | | Cell Phone: | Occupation: | Employer: |
| Last Name: | First Name: | Middle Initial: | Date of Birth (MM/DD/YY): | Relationship to Patient: |
| E-mail: | | Cell Phone: | Occupation: | Employer: |
| Parent/Legal Guardian Preferred Language: | | Additional Phone: | | |

## INSURANCE INFORMATION

| Please check appropriate box, the patient is: ☐Self Pay ☐Insured ☐Government Funded | *If insured, please complete section below* |
|---|---|

Patient's relationship to subscriber: ☐ Self   ☐ Spouse   ☐ Child   ☐ Other   *Specify:*

| Subscriber's Name: | Subscriber's DOB: | Name of Primary Insurance: |
|---|---|---|
| Policy/Member Number: | Group Number: | Claim Address: | Member Services Phone Number: |

| Provider Services Number: | Occupation: | Employer: | Work Phone: |
|---|---|---|---|
| | | | |

## CLINICAL INFORMATION

| Visit related to:  ☐ Second Opinion ☐ Consult    ☐ Surgery   ☐ Other | Diagnosis: | Goal of Care: |
|---|---|---|
| Current Specialty/Referring Physician: | Address: | Phone Number: |
| Referring Physician Email: | Preferred Appointment Date: | Referred by: |

## LOCAL CONTACT INFORMATION IN THE UNITED STATES (IF APPLICABLE)

| Name: | Relationship to Patient: | Preferred Language: |
|---|---|---|
| Local Address: | Local Phone: | E-mail: |

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