

**Pediatric and Adolescent
Clinic of West Texas**



Patient Registration Information
Please *Print* and Complete *ALL* sections below

Patient's Personal Information: Sex: Male Female

Name: _____
Last First Middle Initial
D.O.B.: ____/____/____ Age: _____ Social Security #: _____-____-____
Home #: (____) _____-____ Cell #: (____) _____-____ Work #: (____) _____-____
Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Patient's/Responsible Party Information: Relationship: Self Spouse Child Other: _____

Name: _____
Last First Middle Initial
D.O.B.: ____/____/____ Social Security #: _____-____-____
Home #: (____) _____-____ Work #: (____) _____-____ Cell #: (____) _____-____
Mailing Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Spouse's Information:

Name: _____
Last First Middle Initial
D.O.B.: ____/____/____ Social Security #: _____-____-____
Work #: (____) _____-____ Cell #: (____) _____-____

Patient's Insurance Information: Please Present Insurance Card to Receptionist.

Primary Insurance Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ D.O.B.: ____/____/____
Policy #: _____ Group #: _____ Copay: \$ _____
Relationship to insured: Self Spouse Child Other

Secondary Insurance Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ D.O.B.: ____/____/____
Policy #: _____ Group #: _____ Copay: \$ _____
Relationship to insured: Self Spouse Child Other

Other Siblings: If more than three children list on back of sheet

Name: _____ D.O.B.: ____/____/____ Male Female
Name: _____ D.O.B.: ____/____/____ Male Female
Name: _____ D.O.B.: ____/____/____ Male Female

Other Family Contact: Not Living With You.

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: (____) _____-____ Work #: (____) _____-____ Cell #: (____) _____-____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Leopoldo A. Cabrera, M. D., and any assisting physicians for services rendered. I understand that I am ultimately financially responsible for all charges. In the event that insurance does not cover all or part of the expense, I agree to pay the balance in full. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____

Signature: _____