PEDIATRIC UROLOGY OF HOUSTON

Patient Name_____

# New Patient Registration

## Patient Information

Patient's name _____

DOB_____ Gender_____ SSN _____

Address _____City _____ State_____ Zip_____

Primary Phone _____ Alternate Phone _____

Pediatrician_____ Phone _____ Fax_____

## Responsible Party

Parent's Name_____

DOB_____ Gender_____ SSN _____

Address _____City _____ State_____ Zip_____

Second Parent's Name_____

DOB_____ Gender_____ SSN _____

Address _____City _____ State_____ Zip_____

Emergency Contact _____Phone _____

Relationship to Patient_____

PEDIATRIC UROLOGY OF HOUSTON

Patient Name_____

## Insurance Information

Primary Insured Name _____

DOB_____ Gender_____ SSN _____

Address _____City _____ State_____ Zip_____

Insurance Company Name_____ Phone _____

Member ID _____Group Number _____

Relationship to Patient_____

Insured Employer name/ Address _____

I certify that to the best of my knowledge that the above information is correct and complete. I authorize release of any medical information needed by Houston Pediatric Urology for medical reimbursement under my insurance policy. I authorize my insurance benefits to be paid directly to Houston Pediatric Urology, and I am ultimately responsible for any unpaid services.

Parent/ Guardian Signature _____ Date _____