Children's Medical Group of Austin, PLLC

Patient Information

Patient's Name _____ Patient's DOB _____ M_____ F_____

Patient's Address _____

City _____ State _____ Zip Code _____

Parent Name _____ Parent DOB _____

Primary Phone Number _____ Cell Home Other

Parent Email _____

Parent Name _____ Parent DOB _____

Primary Phone Number _____ Cell Home Other

Parent Email _____

WE MUST HAVE A COPY OF INSURANCE CARD AND PICTURE ID TO OBTAIN INFORMATION AND FILE CLAIMS AT THE TIME OF EACH VISIT

Primary Insurance Policy _____

Policy Holder's Name _____ Policy Holder's DOB _____

Relationship to Patient _____

Insurance ID Number _____ Group ID Number _____

Person Responsible for this bill _____

Billing Address if different than patient's _____

Name of Sibling	DOB	Name of Sibling	DOB
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The following individuals have permission to bring my child in for treatment

_____

_____

Emergency Contact

Name _____ Relationship _____

Phone Number _____ Email _____

Address _____

Signature _____ **Date** _____