LAKE LEWISVILLE PEDIATRICS, LLP
PATIENT REGISTRATION
** PLEASE COMPLETE ENTIRE FORM**

GENERAL INFORMATION

INSURED: LAST NAME FIRST M.I. (CARRIES THE INSURANCE)	TITLE (CIRCLE ONE) MR. MRS. MS.	
STREET ADDRESS:	CITY:	ST/ZIP:
HOME PHONE:	WK PHONE:	EXT.
MOBILE PHONE:	S.S. # XXX-XX-	DL#:
DATE OF BIRTH: December 31 Male	EMPLOYER:	OCCUPATION:
MARITAL STATUS: (CIRCLE ONE) (M) (D) (S) (W)	WORK PHONE:	CELL PHONE:
SPOUSE NAME:		
Best Email:		
OTHER PARENT (Mother/Father)	LAST NAME	FIRST NAME MI
HOME PHONE:	STREET ADDRESS:	
MOBILE PHONE:	CITY:	ST/ZIP:
WORK PHONE:		DATE OF BIRTH: December 31

ALL CHILDREN THAT MAY VISIT OUR OFFICE :

PATIENTS NAME: LAST FIRST MI	D.O.B: December 31	M/F Male	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B: December 31	M/F Male	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B: December 31	M/F Male	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B: December 31	M/F Male	PCP SELECTED
SIBLINGS NAME: LAST FIRST MI	D.O.B: December 31	M/F Male	PCP SELECTED

INSURANCE INFORMATION :

PRIMARY INSURANCE CARRIER:	POLICY ID #:	GROUP #:
OTHER ADULTS AUTHORIZED TO SEEK CARE:	RELATIONSHIP TO PATIENT:	

CONSENT TO TREAT

I hereby authorize employees and agents of Lake Lewisville Pediatrics, LLP, including physician, and other employees and staff members, to render medical evaluations and care to the patient(s) listed above. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

_____ December 31

Signature of Patient, Parent, or Legal Guardian **Date**