2913 Corporate Circle, Suite 300, Flower Mound, TX 75028
Phone 817-997-4084
Fax 817-333-1190
www.flowermoundfamilyhearing.com

PEDIATRIC PATIENT INFORMATION

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____

City, State and Zip: _____

Patient's Date of Birth: _____ Mother's Name: _____

Home Phone: _____ Mother's Date of Birth: _____

Parent/Guarantor Information (Guarantor is the person responsible for payment for service rendered by Family Hearing Practice)

Last Name: _____ First Name: _____ MI: _____

Address: (If different than Patient)_____

City, State and Zip: _____

Date of Birth: _____ Cell Phone: _____

SSN: _____ Work Phone: _____

Email Address: _____

Insurance Information

Primary Insurance:

Plan Name: _____ Policy/ID#: _____ Group #:_____

Subscriber's Name: _____ Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Secondary Insurance

Plan Name: _____ Policy/ID#: _____ Group #:_____

Subscriber's Name: _____ Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical and surgical benefits to Family Hearing Practice, PLLC. **I also agree to abide by Family Hearing Practice 24 hour cancellation policy and understand that I may be charged between $35 and $100 if proper notification is not given.**

_____ _____

Signature of Patient or Guardian Date