STEP PEDIATRICS, P.A.
4800 West Panther Creek, Ste. 100 The Woodlands, TX 77381
281-364-8600 Fax 281-298-2005

PATIENT INFORMATION

PATIENT LAST NAME **FIRST NAME** **MIDDLE INITIAL**

ADDRESS **CITY** **STATE** **ZIPCODE**

FATHER'S NAME **HOME PHONE** **WORK PHONE**

MOTHER'S NAME **HOME PHONE** **WORK PHONE**

EMERGENCY CONTACT (NEAREST FRIEND/RELATIVE) **HOME PHONE** **WORK PHONE**

PATIENT'S SOC.SECURITY# **DATE OF BIRTH** **HOW DID YOU HEAR ABOUT US?**

BILLING PARTY INFORMATION/INSURANCE INFORMATION

INSURED NAME (CARDHOLDER) **ADDRESS**

TX DRIVER'S LICENSE NUMBER **SOC. SECURITY NUMBER** **DATE OF BIRTH**

HOME PHONE **WORK PHONE**

EMPLOYER **ADDRESS**

PRIMARY INSURANCE ADDRESS

GROUP # POLICY # INSURANCE CO. PHONE NUMBER

Fill out this information only if you have secondary insurance carrier on your child; otherwise, skip to next question please.

SECONDARY INSURANCE NAME OF INSURED DATE OF BIRTH

TX DRIVER'S LIC. SOC. SECURITY NUMBER HOME/WORK PHONE

EMPLOYER EMPLOYER ADDRESS

INSURANCE POLICY NUMBER GROUP NUMBER INSURANCE CO. PHONE #

SECONDARY INSURANCE CO. ADDRESS

(Please see next page)

STEP PEDIATRICS, P.A.
4800 West Panther Creek, Ste. 100 The Woodlands, TX 77381
281-364-8600 Fax 281-298-2005

CONSENT FOR MEDICAL TREATMENT

I certify that I am the patient or the parent /legal guardian/or duly authorized agent of the patient (if minor patient) and authorized to consent for medical evaluation and treatment of the patient by the physicians and professional staff of STEP Pediatrics, PA. As the patient or authorized agent for the patient, I understand it is my duty to provide accurate, complete health information regarding the patient to STEP Pediatrics, PA. I can expect my physician(s) to provide information to me regarding the evaluation, diagnosis, and treatment, including risks/benefits of treatment (where applicable) to me. My signature below indicates I have read and agree with this consent.

_____ _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR **DATE**

_____ _____
WITNESS **DATE**

In the event that an accidental needle stick to a health care professional occurs during the course of caring for the patient, blood (from the patient) will be obtained (at no cost to the patient) to test for several blood-borne diseases, including, but not limited to, HIV, Hepatitis B and C. Your signature below indicates understanding and agreement with the above statement.

_____ _____
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN **DATE**

_____ _____
WITNESS **DATE**

FINANCIAL POLICY

I have received a copy of the financial policy of STEP Pediatrics, PA

_____ _____
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN **DATE**

HEALTH INFORMATION PRIVACY PROTECTION

I have received and read a copy of the health information privacy protection act.

_____ _____
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN **DATE**