Seven Hills Pediatrics
6853 Coit Rd Suite 300
Phone: (469) 543-0630
Fax: (469) 543-0620

Patient Information

Patient Name: Last:________________________First:_______________________MI:_____
Address:________________________City:___________________State:______Zip:__________
Phone:______________________Cell:___________________Gender:_______M______F
Soc. Sec#:_____________________Birth Date:____/____/________ Age: ___________

If 18 and Older do you have an Advance Directive Plan- yes or no. If yes please provide a copy to us for your patient chart.

Father's Name:_________________________________Soc. Sec#:____________________
Address:________________________City:___________________State:______Zip:__________
Phone:______________________Cell:__________________ Work #: _____________________
Birth Date:___/___/_____Employer: ____

Mother's Name:_________________________________Soc Sec #: ______________________
Address:________________________City:___________________State:______Zip:__________
Phone:______________________Cell:___________________Work #: _____________________
Birth Date:___/___/_____Employer: ____

**__Email Address__ : ____

Emergency Contact (Other than parents)
Name:_____________________ Address:________________________Phone:________________
Closet Relative:_________________Address:______________________Phone: _______________

Insurance & Billing Information

Person Responsible:___Father ___Mother ___Other - Relationship: ___________________
Primary Ins:_______________________ID#_____________________Grp#:_________________
Subscriber Name:______________________DOB:___/___/_____SSN#:______________________
Ins. Co. Address:_________________________City:___________State:______Zip:_____________
Secondary Ins:_______________________ID#:_____________________Grp#:____________
Subscriber Name:______________________DOB:___/___/_____SSN#:______________________
Ins. Co. Address:_________________________City:___________State:______Zip: _____________

PHARMACY PREFERENCE: ______________________________________

*It is my responsibility to inform the office if my insurance has changed and to know my coverage. It is also my responsibility to keep the office updated on change of address, phone number, and other patient information.
*I authorize the release of any/all information including the diagnosis and the records of any treatment of examination rendered during the period of such care to third payers and/or other health practitioners.
*I authorize and request my insurance company to pay to Seven Hills Pediatrics, associated group benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents. If my account is not paid in full, I understand that I will be required to pay actual costs of collection including court cost and reasonable attorney fees.

____ ______________________
Signature of patient or Guardian (if patient is a minor) Date