LONESTAR MEDICINE AND PEDIATRICS
PATIENT INFORMATION

PATIENT NAME:_____ DOB:_____
INSURANCE:_____ POLICY#:_____
MOTHER'S NAME:_____
FATHER'S NAME :_____
GUARDIAN:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
HOME PHONE:_____
EMERGENCY CONTACT
NAME:_____
PHONE NUMBER:_____
MOTHER'S WORK NUMBER:_____
FATHER'S WORK NUMBER:_____
ANY ALLERGIC REACTION TO ANY MEDICATION?_____
ANY CHRONIC ILLNESS OR ABNORMALITIES?_____
I RECEIVED COPIES OF RELEASE OF INFORMATION POLICY AND PATIENT PRIVACY RIGHTS.

I AUTHORIZE THE FOLLOWING PERSON/PERSONS TO BRING IN MY CHILD TO RECEIVE MEDICAL ATTENTION AND RECEIVE MEDICAL INFORMATION,
_____
_____

I GIVE AUTHORIZATION TO LONE STAR MEDICINE AND PEDIATRICS FOR MEDICAL CARE AND TREATMENT.

SIGNATURE_____DATE_____
RELATION TO PATIENT :_____