TEXAS GULF COAST
medical systems

PHONE: (281) 604-1300 FAX: (281) 724-0355

Print Form

PEDIATRICS - PATIENT INFORMATION RECORD

Fillable Form

NOTE: This form can be filled out from your screen. Just click in the open space beside each query and type in the requested info.

You can click "Highlight Fields" in the top right corner of your PDF Reader to view all the fillable areas. Click the 'email' and/or 'print' button(s) above when finished.

PATIENT INFORMATION

Date: Day Month Year

Patient Name: Last First MI

Sex:

Age:

Date of Birth:

Email:

Address:

City:

State:

Zip:

Home Phone:

Work Phone:

Responsible Party:

Relationship to Patient:

Child's School:

Primary Care Physician:

Phone:

Pharmacy:

Phone:

Drug Allergies:

Who referred you to our doctors?

Emergency Contact:

Phone:

FOSTER CHILD / CPS INFORMATION (Fill out only if applicable)

Custody of Child: ☐ CPS ☐ Adoption Agency ☐ Other _____

Case Worker Name:

Telephone:

Parent's Marital Status (check one) ☐ Married ☐ Divorced ☐ Single

MOTHER'S INFORMATION

Name:

Address:

City:

State:

Zip:

Home Phone:

Work Phone:

Cell Phone:

Email:

Date of Birth:

Drivers License #:

Employed By:

Telephone:

Work Address:

City:

State:

Zip:

Is Mother's Coverage applicable to this child? ☐ Yes ☐ No

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FATHER'S INFORMATION

Name:			
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Email:	Date of Birth:	Drivers License #:	
Employed By:		Telephone:	
Work Address:	City:	State:	Zip:
Is Father's Coverage applicable to this child? ☐ Yes ☐ No			

ALL INSURANCE INFORMATION NEEDS TO BE COMPLETED

Medicaid: ☐ Yes ☐ No	Recipient #:	
Star Medicaid: ☐ Yes ☐ No	Recipient #:	Primary Care Physician:

PRIMARY INSURANCE:

Name of Insurance Company:		Co-pay:	
Company Address:	City:	State:	Zip:
Name of Insured:	Social Security Number:		
Date of Birth:	Relationship to Patient:		
Employer:	Group/Policy #:	ID #:	
Effective Date:	Verification Telephone #:	Pre-Certification Telephone #:	

SECONDARY INSURANCE:

Name of Insurance Company:		Co-pay:	
Company Address:	City:	State:	Zip:
Name of Insured:	Social Security Number:		
Date of Birth:	Relationship to Patient:		
Employer:	Group/Policy #:	ID #:	
Effective Date:	Verification Telephone #:	Pre-Certification Telephone #:	