


TEXAS GULF COAST
medical systems
**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				Day	Month	Year
Date:						
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
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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

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 #:	