Aquarius Pediatrics
Growing Happy Families

11515 Toepperwein Road, Suite 203
San Antonio, Texas 78233

Phone: 210-560-4500
Fax: 210-504-2388

www.aquariuspediatrics.com

Patient Registration Form

Patient(s) name & DOB: _____

Race: _____ Nick name:_____ Age(s) _____

Best phone number: _____

Mother's name & DOB: _____
Contact number & email: _____
Address: _____
Occupation & employer: _____

Father's name & DOB: _____
Contact number & email: _____
Address: _____
Occupation & employer: _____

Parents are? Circle one: Married Divorce Separated Other: _____

Patient resides primarily with, circle one: Both parents Mother Father
Other: _____ Legal guardian: _____

Preferred Language, circle one: English Spanish

How did you find us? Circle one:
Insurance plan Google Close to home Referred by: _____

Siblings (names and birthdates): #1 _____
#2 _____
#3 _____

People who can bring child to appointment:

_____

Pharmacy information: Name _____
Address & phone number _____

Insurance information

Is the patient covered by insurance? (circle one) YES NO (self pay)
Name of primary insurance _____ Insurance # _____
Member ID# _____ group # _____
Responsible party's name & DOB _____
Responsible party's occupation & employer _____
Patients relationship to subscriber _____

Is there a secondary insurance? YES (enter below) NO

Secondary Insurance information
Name of insurance _____ Insurance # _____
Member ID# _____ group # _____
Responsible party's name & DOB _____
Responsible party's occupation & employer _____
Patients relationship to subscriber _____

Insurance card- Please present a current insurance card at first visit and any subsequent visit if there is a change in insurance.

The above information is true and to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Aquarius Pediatrics or insurance company to release any information required to process my claims.

Parent/ Guardian name: _____

Parent/ Guardian signature: _____

Today's Date: _____

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Consent To Treat Minor

I hereby give consent to Aquarius Pediatrics to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any medical assistant or nurse practitioner on the staff of Aquarius Pediatrics to the minor(s) named below.

I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Aquarius Pediatrics recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Minor #1: Name _____ Date of Birth _____

Minor #2: Name _____ Date of Birth _____

Minor #3: Name _____ Date of Birth _____

Print Name: _____

Signature: _____

Date: _____

Please specify relationship to minor, circle one:

Parent with legal custody Guardian with legal custody

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Authorization for Release of Medical Information

Patient Name: _____

Date of Birth: _____

I, _____, hereby authorize the release of medical information **TO** :

Aquarius Pediatrics
11515 Toepperwein Rd, Suite 203
San Antonio, TX 78233
Phone 210-560-4500 Fax 210-504-2388

FROM:

Doctor/Clinic/ Hospital: _____

Address:_____

_____

Phone: _____ Fax: _____

Please release the following:
___ All health information (including growth charts and vaccination records)
___ History/ Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Other (specify) : _____
___ Diagnostic Test Reports
___ Radiology / Images
___ Lab Results
___ Pathology Reports

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information
___ No, I do not consent to the release of this information

Purpose of Disclosure: ___ Treatment / Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Print Name : _____

Relationship to Patient : _____

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I have read, acknowledge and accept the Aquarius Pediatrics policies given to me.

Parent/ Guardian signature: _____
Today's date: _____

I have read, acknowledge and accept the Assignment of benefits form for Aquarius Pediatrics given to me.

Parent/ Guardian signature: _____
Today's date: _____

I have read, acknowledge and accept the Waiver Form for Aquarius Pediatrics given to me.

Parent/ Guardian signature: _____
Today's date: _____

I have read, acknowledge and accept the HIPPAA Notice of Privacy Practices for Aquarius Pediatrics given to me.

Parent/ Guardian signature: _____
Today's date: _____

Child(rens) names:

_____

_____