

NEW BRAUNFELS PEDIATRIC ASSOCIATES, P.A.

1535 E. Common Street, & Annex Bldg. 1533 E. Common Street, New Braunfels, Texas 78130

& 237 Hunters Village, New Braunfels, Texas 78132

Office # (830)625-9153 Fax # (830)609-0572

Timothy W. Owens, M.D., Mark D. Statler, M.D., Jay S. Weinberg, M.D., Sarah E. Rieger, M.D., Ramona Peck, M.D., Michelle L. Bernardy, M.D., Rachel L. Hayden, PA-C., Wendi H. Reagan, RN, CPNP, Ismaela Gomez, DNP, RN, CPNP, Kristen Roach, RN, CPNP

Thank you for choosing our office. In order to service you properly, we will need the following information.

PATIENT INFORMATION

NAME: Last	First	M.I.	Age	Gender
Date of Birth	Patient Home Phone #			
Patient Address	City	State	Zip Code	
Child Lives With	Emergency Name & Relationship		Emergency Phone #	
Mother's Name	Home Phone #	Cell Phone #		
Mother's Address	City	State	Zip Code	
Mother's Date of Birth	Social Security #	Driver's License #		
Mother's Employer	Phone #	Mother's Email Address		
Father's Name	Home Phone #	Cell Phone #		
Father's Address	City	State	Zip Code	
Father's Date of Birth	Social Security #	Driver's License #		
Father's Employer	Phone #	Father's Email Address		
Sibling's Full Names				
Reason for today's visit				
Former Doctor	Referred By			

INSURANCE INFORMATION

(Please present insurance card at time of visit)

Name of Primary Insurance Company	Insurance Company Address	City	State	Zip Code	
Name of Policy Holder	Date of Birth	Policy Holder Address	City	State	Zip Code
Group #	Policy #	Co-pay Amount			
Name of Secondary Insurance Company	Insurance Company Address	City	State	Zip Code	
Name of Policy Holder	Date of Birth	Policy Holder Address	City	State	Zip Code
Group #	Policy #	Co-pay Amount			

I hereby authorize payment of insurance benefits to Timothy W. Owens, M.D., Mark D. Statler, M.D., Jay S. Weinberg, M.D., Sarah E. Rieger, M.D., Ramona Peck, M.D., Michelle L. Bernardy, M.D., Rachel L. Hayden, PA-C, Wendi H. Reagan, RN, CPNP, Ismaela Gomez, DNP, RN, CPNP, and Kristen Roach, RN, CPNP. I also authorize the above named parties to release information for the purpose of payments of benefits. A photocopy shall be as valid as the original.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. For any extenuating or unusual circumstances, please contact clinic administrator Mary Owens, R.N., CMPE, CMM, CPC, CPEDC at (830) 625-9153, ext. #215.

Signature	Date
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