Mansfield Pediatrics Patient Information

Patient Information:
Name:____
Date of Birth: ___/___/_____ Sex: M / F
Address:____
City:_______________________State:________ Zip:___________
Home Phone: (_______) ________-____________
Parent Email ______________________________________

Preferred Pharmacy (Address, Phone Number and/or Cross Street):

____

Parents or Guardians Names:
Child lives with: Mother___ Father___ Other_________________

Father's Name:_____________________________ DOB ________
Address:____
City:_______________________State:________Zip:___________
Home Phone:(_______) ________-____________
Employer: ______________________________
Work Phone: (_______) ________-____________
Cell Phone: (_______) ________-____________

Mother's Name:____________________________ DOB ________
Address:____
City:_______________________State:________Zip:___________
Home Phone(______) ________-____________
Employer: ______________________________
Work Phone: (______)________-____________
Cell Phone: (______) ________-____________

Emergency Contact:__________________ Relationship: ______________
Home Phone: (_______) ________-__________
Work Phone: (_______) ________-__________
Cell Phone: (_______) ________-__________

Insurance through: Mother___ Father___ Effective Date: __________
Primary Insurance: ______________________________________
Group Number:__________________ID Number:__________________
Address:____
City:_______________________State:________Zip:___________
Phone:(_______) ________-__________

HOW DID YOU HEAR ABOUT US: *Please take a moment and let us know ~ THANK YOU!*
__ Friend / Family Referral __ Internet Search __ Chamber of Commerce __ Facebook
__ Mansfield Cares __ OB/GGYN Referral __ Mansfield Methodist Hospital
__ Other______________________________________

MANSFIELD PEDIATRICS, PLLC
1825 Cannon Drive
MANSFIELD, TEXAS 76063
PHONE (817) 453-7770 / FAX (817) 453-7703

Non-Parental Authorization for Consent to Medical/ Surgical Care and Treatment

I, ____, parent / legal guardian of:

Child(ren):

NAME	DOB

Do hereby give my authorization and consent for my child (named above) to be seen by Providers at Mansfield Pediatrics, PLLC and consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). This is also permission to bring my child(ren) for well checks and all necessary immunizations that are routinely given at the well visit.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

Signature	Relationship to Child(ren)	Date

Parent/Guardian Names and Relationship:

Printed Name	Relationship to Child(ren)

Authorized Person(s):

Name	Relationship to Child(ren)