Ennis Pediatric and Adolescent Health Care Center, P.A.

805 S. Clay Street, Ennis, Tx 75119 -- 972-875-8300
Katherine Brown, M.D. -- Elaine Donet, FNP-BC -- Becky Lucas, DNP -- Jamie Rowland, CPNP

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		PHONE
CLAIMS MAILING ADDRESS		
NAME OF PRIMARY INSURED OR POLICY OWNER	DATE OF BIRTH	PATIENT ID NUMBER
POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE
RELATIONSHIP TO POLICY HOLDER ❑ CHILD ❑ STEPCHILD ❑ GRANDCHILD		

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		PHONE
CLAIMS MAILING ADDRESS		
NAME OF PRIMARY INSURED OR POLICY OWNER	DATE OF BIRTH	PATIENT ID NUMBER
POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE
RELATIONSHIP TO POLICY HOLDER ❑ CHILD ❑ STEPCHILD ❑ GRANDCHILD		

CORRESPONDENCE PREFERENCES

MAY WE CALL YOUR ❑ CELL PHONE ❑ HOME PHONE ❑ WORK PHONE	MAY WE CONTACT YOU BY EMAIL? ❑ YES ❑ NO
WHAT IS YOUR PREFERRED CORRESPONDENCE WITH OUR OFFICE? ❑ CELL PHONE ❑ HOME PHONE ❑ WORK PHONE ❑ E-MAIL	
MAY WE LEAVE MESSAGES ON YOUR ❑ CELL PHONE ❑ HOME PHONE ❑ WORK PHONE ❑ E-MAIL	

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PATIENT GENERAL INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH	GENDER ❑ MALE ❑ FEMALE	LANGUAGE
STREET ADDRESS	CITY, STATE, ZIP CODE	
RACE	ETHNIC GROUP	

PARENT INFORMATION

FATHER'S NAME		BIRTH DATE	EMPLOYER
STREET ADDRESS		CITY, STATE, ZIP CODE	
HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL ADDRESS
MOTHER'S NAME		BIRTH DATE	EMPLOYER
STREET ADDRESS		CITY, STATE, ZIP CODE	
HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL ADDRESS

EMERGENCY INFORMATION

EMERGENCY CONTACT NAME		RELATIONSHIP TO PATIENT
HOME PHONE	CELL PHONE	WORK PHONE

PREFERRED PHARMACY

PHARMACY NAME AND LOCATION	PHARMACY PHONE

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SIBLINGS (Please list any siblings of the patient who are patients at Ennis Pediatrics.)

NAME	DOB
NAME	DOB
NAME	DOB

PREAUTHORIZATION TO TREAT MINORS

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. This may include, but is not limited to, a grandparent, babysitter or family friend. Please be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

☐ I authorize Ennis Pediatrics and its personnel to provide medical care to this child in my absence. _____initials

☐ I <u>do not</u> authorize Ennis Pediatrics to provide medical care in my absence. _____ initials