TRINITY PEDIATRICS / GALAXY PEDIATRICS

6105 Windcom Court , Suite #100
Plano , Texas 75093
Ph: 972-473-9063 Fax: 972-473-9059

556 Bluebird Lane
Red Oak , Texas 75154
Ph: 972-617-6660 Fax: 469-218-0070

Date:_____ ***Referred by:*** *_____*

Patient Last Name: _____ First Name:_____M.I.____
Date of Birth: _____ Gender (M/F)_____
Address: _____City: _____
State: _____ Zip Code: _____ Phone:_____

Mother Last Name: _____ First Name:_____M.I.____
Date of Birth: _____ Gender (M/F)_____
Address: _____City: _____
State: _____ Zip Code: _____ Phone:_____
Driver License /ID #:_____ Employer:_____
Occupation:_____ Work Ph: _____

Father Last Name: _____ First Name:_____M.I._____
Date of Birth: _____ Gender (M/F)_____
Address: _____City: _____
State: _____ Zip Code: _____ Phone:_____
Driver License /ID #:_____ Employment:_____
Occupation:_____ Work Ph: _____

Are both parents Legal Guardians? _____ If not , Name of Legal Guardian _____

(If Legal Guardian of Child is someone other than parent ,please provide a court ordered legal document)

Please Continue to the other side:

TRINITY PEDIATRICS / GALAXY PEDIATRICS

Guardian Last Name: _____ *First Name:*_____*M.I.*____
Date of Birth: _____ *Gender (M/F)*_____
Address: _____*City:* _____
State: _____ *Zip Code:* _____ *Phone:*_____
*Driver License /ID #:*_____ *Employment:*_____
*Occupation:*_____ *Work Ph:* _____

I _____*(guardian signature) authorize the following person/s to bring* _____ *(Child's name) to Trinity Pediatrics / Galaxy Pediatrics for patient care.*

Full Name: _____ *Relation to Pt.:*_____

Full Name: _____ *Relation to Pt.:*_____

Full Name: _____ *Relation to Pt.:*_____

(Authorized person must present photo identification at check in)

Emergency Contact:

Name: _____*Ph:* _____ *Relation* _____

Name: _____*Ph:* _____ *Relation* _____

Name: _____*Ph:* _____ *Relation* _____