Victoria Pediatrics and Adolescent Assoc.

Dr. Felix Regueira

Patient Information Form

(Please print clearly and complete all blanks)

Date_____

Patient's Name_____ Sex _____DOB_____/_____/_____

SS#_____ Allergies (medicines/food)_____

Preferred Pharmacy_____Address_____Phone_____

Patient Portal Email: _____ (can only use one email)

Mother's Name_____ DOB_____/_____/_____SS#_____

Home Address_____ City _____ Zip_____

Home Phone _____ Cell phone_____

Employer Name_____ Work phone_____

Father's Name_____DOB____/____/_____SS#_____

Home phone _____ Cell phone_____

Home address if different from mother's_____ City/Zip_____

Employer Name_____ Work Phone _____

Child's primary legal custodian (check one) Mother____ Father____ Grandparent____ Other____ Parents married/together_____

Race (check one) White_____ Hispanic_____ African American_____ Asian_____ Refused to report_____

Ethnicity (check one) Hispanic/Latino_____ Not Hispanic/Latino_____ Refused to report_____

Language (check one) English_____ Spanish_____ Other_____ Translator requested _____ Declined_____

<u>Insurance Information- Primary</u>

Name of Insurance _____ Policy Number _____ Group number _____

Claim address_____ Phone number_____

Policy Holder's Name_____ DOB____/_____/_____ SS#_____

Relationship to child _____

<u>Insurance Information- Secondary</u>

Name of Insurance _____ Policy Number _____ Group number _____

Claim address _____Phone number_____

Policy Holder's Name_____ DOB____/_____/_____ SS#_____

Relationship to child _____

Please update office with any insurance changes.

Signed: Parent/Guardian if minor) _____

Victoria Pediatrics and Adolescents Assoc., Felix F. Regueira, M.D.

4304 Retama Circle, Victoria, Texas. 77904, 361-576-2134

Consent for Non-Urgent Pediatric Care Form

I have the legal right to delegate such consent to the decision maker, who is an adult and legally and medically competent to exercise the authority to delegate I understand that protected patient health information, as well as certain family history, may be shared with the decision maker, who is listed above, to facilitate informed decision-making. I am also giving this decision maker the right to consent to recommended immunizations in my absence.

My child(ren)'s #1 emergency contact(s) as my decision maker for consenting to non-urgent medical care for my child(ren) is:

Name:_____Phone:_____ Relationship _____

Additional Adults:

Name:_____Phone:_____ Relationship _____

Name:_____Phone:_____ Relationship _____

For my children listed below:

Name_____d.o.b._____

Name_____d.o.b._____

Name_____d.o.b._____

Name_____d.o.b._____

Name_____d.o.b._____

Name_____d.o.b._____

Emergency Contact Information

If the nature of the medical care is NOT routine, please try to contact me regarding the healthcare of my child(ren) at the following telephone number(s):

Mother_____ Father_____

Cell#_____Cell#_____

Daytime #_____Daytime#_____

Evening#_____Evening#_____

Name:_____Phone:_____

If you are unable to contact me for any reason, you may rely on the decision maker, named above, for consent

**Legal Guardian's signature_____ date_____

Signature of witness_____date_____

Revised October 10, 2019