Bee Well Pediatrics Endocrinology

Virginia Cortes Araiza, MD, PLLC

Child's Name:_____ Date of Birth: _____

Gender: Male Female Child's Social Security # _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____
Primary Alternate

Parent/ Guardian Demographics

Father's Name: _____ Mother's Name: _____

Date of Birth: _____ Date of Birth: _____

Social Security #: _____ Social Security: _____

Employer Name: _____ Employer Name: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Pharmacy Name/ #:_____

Do any siblings come to our office:_____

Who Referred you to us: The Motherhood Center Houston Baby The Bump Exp Mothers Guide Other_____

Emergency Contact Name: _____ Phone: _____

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/ medical benefits to Dr. Virginia Araiza, PLLC, for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. Any services rendered outside of the clinic, i.e.: lab work, blood tests, x-rays, etc., that are not covered by insurance will be my financial responsibility.

Authorization to Release Information

I hereby authorize Dr. Virginia Araiza, PLLC, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

_____ _____
Patient Name (Please Print) Date

_____ _____
Parent/ Guardian Name (Please Print) Signature