Hilltop Pediatrics
300 North Highland Ave, Suite 542
Sherman, TX 75092

# Responsible Party Information

Please PRINT and complete ALL sections below!

**PATIENT'S NAME**

Name: _____ _____ _____
Last Name First Name Initial

**MOTHER/LEGAL GUARDIAN** (Please circle) Name _____
Last First Middle

Date of Birth: _____ / _____ / _____ Social Security #: _____ / _____ / _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Driver's License#: _____ State _____ E-mail Address _____

Place of Employment _____ Occupation _____

Name of Spouse (if different than Father/Legal Guardian):_____

**FATHER/LEGAL GUARDIAN** (Please circle) Name _____
Last First Middle

Date of Birth: _____ / _____ / _____ Social Security #: _____ / _____ / _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Driver's License#: _____ State _____ E-mail Address _____

Place of Employment _____ Occupation _____

Name of Spouse (if different than Mother/Legal Guardian):_____

**INSURANCE INFORMATION** Please present insurance card(s) and drivers license to receptionist.

**PRIMARY Insurance Name**: _____ Phone #: _____

Address: _____ City: _____ State: ___ Zip: _____

Name of insured: _____ Social Security #: _____ Date of birth: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Employer _____

Policy #: _____ Group #: _____

**SECONDARY Insurance Name:** _____ Phone #: _____

Address: _____ City: _____ State: ___ Zip: _____

Name of insured: _____ Social Security #: _____ Date of birth: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Policy #: _____ Group #: _____

Please initial below:

_____ By signing this form, I agree to take full financial responsibility for this child's account independent of what a divorce decree may state. Also, I understand that my estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is payable by me within 30 days.

_____ I herby authorize payment of medical insurance benefits, if any, to be made directly to Hilltop Pediatrics.

Signature of the person completing the form _____ Date _____

Printed Name _____ Relationship to Patient _____