AR TEXAS PEDIATRICS
Health is LIFE

Dr. Aseema Raoshan, MD

LOCATION: 1
SOUTHEAST PROF BLDG
11914 ASTORIA BLVD, SUITE 450
HOUSTON, TEXAS, 77089

LOCATION: 2
IMPERIAL MEDIAL CENTER
1111 HIGWAY 6 SOUTH SUITE 120
SUGARLAND TX 77478

Who may we thank for referring you? _____ Did Dr. Raoshan see your child in the hospital? _____
Have you arranged to have your child's Medical records sent here from another doctor?_____
_____

Child's Full Name: _____ Date of Birth: _____/_____/_____ Sex: M __F ___
Address where child lives: _____

Phone number where child lives: _____ Child's SS#: _____
Names of other Children:
_____ Date of Birth: _____
_____ _____Date of Birth: _____
_____ Date of Birth: _____

Father's Full Name: _____ Date of Birth: _____ Cell: _____
Father's Home Phone #: _____ Work Phone #: _____ SS#: _____
Father's Employer Name & Address: _____

Mother's Full Name: _____ Date of Birth: _____ Cell: _____
Mother's Home Phone #: _____ Work Phone #: _____ SS#: _____
Mother's Employer Name & Address: _____

The person legally responsible for payment of this account: _____
Address: _____Tel#:_____
Billing Address, if different from child's _____
Relationship to patient: _____
_____
EMERGENCY NUMBERs: (person NOT living with child)
Name: _____
Address: _____Tel#:_____
_____

PRIMARY INSURANCE CO: _____ Pharmacy: _____
Group#: _____
Insured's I.D.#: _____
Insurance Company Tel#: _____
Ins Co. Address: _____
Name Policy is listed under:_____ _____

I hereby consent to, and request the medical treatment be provided to my children in accordance with the plan of care established by the Physician. I authorize the release of any medical information necessary to process claims, and also authorize the payment of medical benefits to the Physician described herein. If no payment is received from the Insurance Company, I agree to pay the balance.

Signature: _____ Date: _____

********** PAYMENT FOR ALL SERVICES IS REQUIRED AT THE TIME OF SERVICE **********