



Reese A. Mathieu
— PEDIATRICIANS —

3601 North Star
Richardson, Texas 75082

Phone: 972-235-0385
Fax: 972-235-3859

Date _____ Referred by: _____

Children:

Name: _____	Date of Birth _____	Sex _____
Name: _____	Date of Birth _____	Sex _____
Name: _____	Date of Birth _____	Sex _____
Name: _____	Date of Birth _____	Sex _____

Children reside with _____

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

City: _____ ZIP: _____ City _____ ZIP _____

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

Email Address: _____

SS# _____ SS# _____

D.O.B. _____ D.O.B. _____

License# _____ License# _____

Employer _____ Employer _____

Pharmacy name and phone # _____

Person Carrying Primary Insurance: _____

Person to notify if you cannot be reached: _____ Phone: _____

Assignment of Benefits:

I hereby authorize the release of any medical information necessary to process an insurance claim And assign payment to be made directly to **Reese A. Mathieu, M.D.** A photocopy of this agreement is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE STATUS OF MY INSURANCE CLAIMS.

Signed: _____ Date: _____

Consent to Treat

By signing this form, I allow Dr. Mathieu or his covering physician to treat my child in my absence:

Signed: _____ Date: _____