GRACE M. SALINAS-GARCIA, M.D., P.A.
CHILD AND ADOLESCENT PSYCHIATRY
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
9518 TIOGA DR.
SAN ANTONIO, TEXAS 78230

TEL # (210) 495-4888 FAX # (210) 495-1333

CHILD AND ADOLESCENT INFORMATION RECORD

CHILD'S NAME:_____ BIRTH DATE:_____AGE:_____
ADDRESS:_____PLACE OF BIRTH:_____
CITY/ZIP CODE:_____LENGTH AT PRESENT LOCATION:_____
HOME PHONE:_____ALT PHONE:_____
SCHOOL:_____GRADE:_____TEACHER'S NAME:_____
DRUG ALLERGIES:____YES____NO IF YES, LIST:_____
HOW DID YOU HEAR ABOUT OUR PRACTICE:_____

PRESENT FAMILY INFORMATION (FAMILY CURRENTLY RESPONSIBLE FOR CHILD)

FATHER'S NAME:_____AGE:_____EDUCATION:_____
FATHER'S OCCUPATION:_____SSN:_____
MOTHER'S NAME:_____AGE:_____EDUCATION:_____
MOTHER'S OCCUPATION:_____SSN:_____
IS EITHER PARENT A STEP OR ADOPTIVE PARENT:_____IF YES, WHICH PARENT?_____
ARE THE NATURAL PARENTS SEPARATED? _____DIVORCED?_____CUSTODIAL PARENT?_____
FAMILY PHYSICIAN'S NAME:_____

LIST ALL CHILDREN IN FAMILY

NAME	AGE	SCHOOL GRADE

PRIMARY INSURANCE COMPANY:_____
ADDRESS:_____PHONE#_____
POLICY #_____GROUP#_____
NAME OF POLICY HOLDER:_____
SECONDARY INSURANCE COMPANY:_____
ADDRESS:_____PHONE#_____
POLICY #_____GROUP#_____
NAME OF POLICY HOLDER:_____
WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY (THAT DOES NOT RESIDE WITH YOU)_____
RELATIONSHIP TO PATIENT:_____PHONE#_____

INSURANCE AUTHORIZATION

I hereby authorize GRACE SALINAS-GARCIA, MD, PA, to furnish information to my insurance carriers concerning my illness and treatment.

ASSIGNMENT OF BENEFITS

I hereby assign to GRACE SALINAS-GARCIA, MD, PA, payment for medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE:_____DATE:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand payment is expected at the time of service for office visits unless other arrangement have been made. GRACE SALINAS-GARCIA, MD, is responsible for providing documentation for me to submit to my insurance carrier for reimbursement. I understand co-payments and deductible payment for certain HMO's and Champus are accepted in lieu of complete payment at the time of my first visit. Since Dr. Salinas is non-participating physician to certain insurances, I will be required to pay the fees in full prior to my visit.

I understand if my insurance company fails to pay for any services rendered to my dependents or me, I am finicially responsible for payment.

RESPONSIBLE PARTY:_____DATE:_____