Brian Despinasse II, M.D.
AND ASSOCIATES

FERTILE CRESCENT PEDIATRICS

730 Colonial Drive, Suite B • Baton Rouge, La 70806 • Phone: 225.924.7343 • Fax: 225.924.7347 • www.fertilecrescentpediatrics.com

Patient's Name: _____ Patient's Date of Birth: ____/____/_____
(Please put middle initial)

Sex: M / F SSN: _____-_____-_____ Home Phone: ( ) _____-_____

Race/Ethnicity:_____ Language: _____

Cell Phone: ( ) _____-_____ Baby's Birth Weight:_____#ofWeeks:_____Age:_____

Street Address: _____City:_____State:_____Zip:_____

Referred By: (How did you hear about us?) _____Email:_____

Clinician of Choice: ___ Dr. Brian P. Despinasse, II ___ Daisy Castaneda, PA-C ___

Mother's Name: _____ Date of Birth: ___/____/___ SSN: ____-____-____

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Employer's Name: _____ Work Phone: ( ) _____-_____ Ext: _____

Father's Name: _____ Date of Birth: ____/____/_____SSN:_____-____-____

Home Phone: ( ) _____-_____ Cell Phone: ( )_____-_____

Employer's Name: _____ Work Phone: ( ) _____-_____Ext: _____

Responsible Party/Insured: _____ Phone: ( ) _____-_____

Mailing Address: _____ City: _____ State: _____Zip:_____

Insurance Company Name: _____Insurance Company Phone: ( ) _____-_____

Insurance Policy Number: _____ Group Number: _____

Relationship to Patient: Parent Self Other: _____

Is your Child allergic to any Medications (Y / N)? ____ Is your child allergic to any foods, tapes, dye, or other (Y / N)? ___If yes, please describe the type of allergic reaction:

_____

I authorize the use of this form, and information on all my insurance submissions, I authorize release of information to my insurance company(ies), I authorize payment directly to my doctor, I understand I am responsible for my bill, I permit a copy of this authorization to be used in place of the original, I authorize my doctor to act as my agent in helping me to obtain payment from my insurance company(ies), I understand I am responsible for payment in full if my insurance does not cover services, I understand that co pays or deductibles are required at time of services to my doctor.

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Consent to Treat Form

As parent or legal guardian (circle one) for _____, I give permission for the persons listed below to authorize any medical treatment my child may need, in the event I am not able to accompany my child.

Name	Date of Birth	Relationship to Child
_____	___/___/____	_____
_____	___/___/____	_____
_____	___/___/____	_____
_____	___/___/____	_____
_____	___/___/____	_____

_____ _____
Signature of Parent or Guardian Date

In case of an emergency, contact (if different from Parent):

_____

Phone :( ) _____- _____

Signature on File