



LIVINGSTON/CLEVELAND PEDIATRICS

• Marlo Brawner, MD, FAAP*

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle: _____

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

Child's Address: _____
CITY STATE ZIP

Home Phone #: _____ Cell Phone #: _____

Primary Contact Number: HOME CELL Best time to call: Morning Afternoon

Parent's E-mail: _____

Who does child live with: () Mom Only () Dad Only () Parents () Relative () Legal Guardian () Other: _____

Patient's Primary Language: English Spanish Other: _____

Parent/Legal Guardian's Primary Language: English Spanish Other: _____

Does the parent/legal guardian require an interpreter? Yes No

GUARANTOR INFORMATION: (Person responsible for any bill)

Full Name (Last, First, Middle): _____

Relationship to Patient: _____ Emancipated Minor? YES NO

Street Address (if different than Patient's): _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Driver's License #: _____ State Issued: _____ Exp. Date: _____

Employer Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Work #: _____ Cell #: _____ Home #: _____

400 Ogletree Drive
Livingston, Texas 77351
#936-328-8812

Fax: 936-328-8815

203 N. College, Suite 1001
Cleveland, Texas 77327
#281-592-6000

* Board Certified by the American Board of Pediatrics



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OTHER CHILDREN IN THE FAMILY THAT LIVE WITH THE PATIENT:

1. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
2. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
3. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
4. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO
5. _____ Sibling Half-Sibling Step-Sibling
NAME _____ DOB _____
❖ Does the child above use Livingston/Cleveland Pediatrics as their Primary Care Provider? YES NO

ADDITIONAL ACCOUNT ACCESS AND/OR EMERGENCY CONTACTS:

Please list any person(s) who may bring the patient to their appointments or have access to the patient's health information.

1. Father's Name: _____ Phone #: _____
2. Mother's Name: _____ Phone #: _____
3. Legal Guardian's Name: _____ Phone #: _____
** LEGAL PAPERWORK NEEDED**
4. Legal Guardian's Name: _____ Phone #: _____
** LEGAL PAPERWORK NEEDED **
5. Authorized Name: _____ Phone #: _____
Relationship: _____
6. Authorized Name: _____ Phone #: _____
Relationship: _____

The individuals listed above are over 18 years of age and have my permission to seek and obtain medical care and discuss treatment of my child with Livingston/Cleveland pediatrics clinic and its employee's. This request may be revoked and/or changed at any time in writing, and expires one year from day of completion, whichever comes first. Written notification of the change must be given within 30 days of the effective date. No information will be released regarding your child via phone or at the clinic, if the individual is not listed on the authorization form. Unless court documents are on file with our clinic showing a revocation of mom's or dad's rights, they are automatically authorized by state law.

Any changes to this authorization must be received in writing within 30 days of effective date.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____

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