Roger S. Knapp, M.D.
David W. Nichols, M.D.
480 W. Southlake Blvd.
Suite 133
Southlake, TX 76092
817-329-9234

Patient Registration Information

PLEASE PRINT THE FOLLOWING INFORMATION: Patient's SS#: ______________________

Patient Name: ________________________ , ______________________________________ Sex: M [ ] F [ ]
Last *First* *Middle*

Date of Birth: ____________________________ Home Phone: _________________________

Father's Name: _____________________________________ DOB __________________ SS# ____________________

Mother's Name: ____________________________________ DOB ___________________ SS# ____________________

Address: ____ City: ___________________ State ________ Zip ________

Father's Employer: ____ Work Phone: __________________

Mother's Employer: ____ Work Phone: __________________

In Case of Emergency, Please Notify: Name: ____

Phone Number ____________________________ Relationship ____

INSURANCE INFORMATION

Primary Insurance Name: ________________________________ Name of Insured: __________________________________

ID or Policy Number: ___________________________________ Group Number: ___________________________________

Secondary Insurance Name: ______________________________ Name of Insured: __________________________________

Id or Policy Number: ___________________________________ Group Number: ____________________________________

I hereby give my permission to Cook Children's Physician Network to examine and administer treatment as may be deemed necessary. The undersigned agrees that all services are rendered on a paid basis only. If collection becomes necessary, the undersigned shall pay all costs including attorney's fee. I authorize release of information as may be requested by my insurance company.

Signature: ____ Date: _________________________________

Print Name: ____ Account # ____________________________
Office will give this.