900 Jerome St. Ste 102
Fort Worth, Tx 76104
Phone: 817-922-0800
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METROPLEX PEDIATRICS, PA

DR. BABATUNDE DOSU, M.D.

6905 Davis Blvd, Ste 200
North Richland Hills, Tx 76182
Phone: 817-576-8200
Fax: 817-922-0805

SECTION I	**PATIENT INFORMATION**	Date:
Last Name:	First:	Middle:
DOB: / /	Age:	Sex: ❑ Male ❑Female
Address:	City:	State: Zip:
Phone: ( )	Work: ( )	Cell: ( )
Email:		
Race: ❑ American Indian ❑Asian ❑African American ❑Native Hawaiian/Other Pacific Islander ❑White ❑Other	Ethnic Group: ❑Hispanic or Latino ❑Non-Hispanic or Latino	
If Student, Name of School	City/State:	❑FT ❑PT
***Newborns Only: Did Dr. Dosu see the baby in the hospital?** ❑Yes ❑No		
Which hospital was the baby born at:		
Father's Name:	Employer:	Work: ( )
DOB: / /	SS# : - -	
Mother's Name:	Employer:	Work: ( )
DOB: / /	SS# : - -	
Emergency Contact:		Phone: ( )
Whom may we thank for referring you?		

SECTION II	**RESPONSIBLE PARTY**	
Name:	Relationship to Patient: ❑Self ❑Spouse ❑Parent ❑Other _____	
Address:		
City:	State: Zip:	Phone: ( )
Employer:	Work: ( )	SS# : - -

SECTION III	**INSURANCE INFORMATION**	
Name of Insured:	DOB: / /	Relationship to Patient:
SS# : - -	Name of Employer:	Work: ( )
Address of Employer:	City: State:	Zip:
Insurance Company:	Grp#:	ID#:
Ins Co Address:	Ins Co Phone:	
DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑Yes ❑No IF YES, COMPLETE THE FOLLOWING		
Name of Insured:	DOB: / /	Relationship to Patient:
SS# : - -	Name of Employer:	Work: ( )
Address of Employer:	City: State:	Zip:
Insurance Company:	Grp#:	ID#:
Ins Co Address:	Ins Co Phone:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Metroplex Pediatrics, PA or my insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*