La Altura Pediatrics
Dominion Hills Plaza
21195 IH-10 West, Suite 2101
San Antonio, TX 78257

SINGLE PROCEDURE FORM

Date: _____________________

Patient Name: ___ ____

Guarantor Name: ____

Guarantor Address: ____

Guarantor City: ___________________________ State: ___________________________ Zip Code: _____________

Procedure To Be Performed: ____

Primary Care Physician: ___________________________ Primary Care Physician Phone #: __________________

Insurance Information

Insurance Name: _________________________ ID #: ___________________________ Group #: _______________

Insurance Address: ______________________ State: ____________________________ Zip Code: _____________

Credit Card Information

Card #: _________________________________ Exp. Date: ______________________ SSC#: ___________________

I agree to pay all charges not covered by the insurance company listed above. I understand that all payments are due at the time of service.

____ _____________________

Signature of Parent or Guardian Date