

Pediatric Associates of Plano

Account Number: _____

Pharmacy/Number: _____

Patient Information Sheet

Fill Out Form Completely

Welcome to our office! We are happy to serve your healthcare needs. The information requested on this form will enable us to serve you more efficiently. It is important that this information be kept current. We require an update each year and with any changes. Thank you!

Patient / Sibling information

Name: _____	DOB: _____	M/F _____	Name: _____	DOB: _____	M/F _____
Name: _____	DOB: _____	M/F _____	Name: _____	DOB: _____	M/F _____
Name: _____	DOB: _____	M/F _____	Name: _____	DOB: _____	M/F _____
Name: _____	DOB: _____	M/F _____	Name: _____	DOB: _____	M/F _____
Name: _____	DOB: _____	M/F _____	Name: _____	DOB: _____	M/F _____

Please Circle Status of Parents of Patients Listed Above: Married, Single, Widowed, Separated, Divorced

Primary residence with whom above child(ren) live with: Parents, Mother, Father, Other _____

Parent Information Of Above Patients

Mother's Name: _____	Father's Name: _____
Mother's Maiden Name: _____	
Address: Street: _____	Address: Street: _____
City: _____ State: _____	City: _____ State: _____
Zip: _____ County: _____	Zip: _____ County: _____
Home #: _____ Cell#: _____	Home #: _____ Cell#: _____
Work #: _____ Preferred Contact # H / C / W	Work #: _____ Preferred Contact # H / C / W
Date of Birth: _____ SS#: _____	Date of Birth: _____ SS#: _____
Driver's License #: _____ State: _____	Driver's License #: _____ State: _____
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Preferred Parent Email Address: _____	

<p>For Office Use Only</p> <p>Allergies: _____</p>

Insurance Information

Insured's Name: _____

Relationship to Patient(s): _____

Insured's Date of Birth: _____

Insured's Social Security #: _____

Insured's Employer: _____

Insurance Carrier: _____

ID/Badge #: _____ Group #: _____ Circle: PPO / POS / HMO

I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to Pediatric Associates of Plano, P.L.L.C. for services rendered.

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

Parent's Signature: _____

Date: _____

Consent to Release Patient Health Information

I authorize Pediatric Associates of Plano to leave a detailed message on voice mail at my home, cell and business telephone numbers with all appointment and medical information including test results and billing issues that concern the patient(s)/children on this form.

_____ Release this information to both parents and the following family members.

Please specify name and relationship

Parent's Signature: _____

Date: _____