Pediatric Associates of Plano

Account Number: _____ Pharmacy/Number: _____

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 the information be kept current. We require an update each year and with any changes. Thank you!

List ALL children under our care:

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

Marital status of parents: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Primary residence with whom above children live with: ☐ Parents ☐ Mother ☐ Father ☐ Other _____

Parent Contact Information

Mother's Name: _____	Father's Name: _____
Address: Street _____	Address: Street _____
City _____ State _____ Zip _____ County _____	City _____ State _____ Zip _____ County _____
DOB: _____ Driver's License #: _____	DOB: _____ Driver's License #: _____
Occupation: _____	Occupation: _____
Employer: _____	Employer: _____
Preferred Contact #: _____ Cirlce one: Home / Cell / Work	Preferred Contact #: _____ Cirlce one: Home / Cell / Work
Other contact #(s): _____	Other contact #(s): _____
Email: _____	Email: _____

Please list additional contact information for any step-parent(s), grandparent(s) or other guardian with whom the above patients may live with and/or may accompany the patient for office visits and consent to treatment:

Name:	Relationship to patient:	Contact information:

Please see back of this form to complete insurance information.

For Office Use Only

Patient Allergies:

Insurance Information

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.

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: _____ Insured's SSN: _____

Insured's Employer: _____ Insurance Company: _____

ID #: _____ Group #: _____ Circle one: ☐ PPO /☐POS /☐HMO

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 TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

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 apointment reminders and medical information including test results and billing issues that concern the patient(s) on this form.

In any case where we are unable to reach the parent(s), please list any any step-parent(s), grandparent(s), other guardian or family member we may release information to by phone:

Name:	Relationship to patient:	Contact #:

I have read, understand, and have fully completed all portions of this document to the best of my knowledge and confirm my consent to release information by phone to both parents and those family members/others listed above.

Parent Signature: _____ Date: _____

Email Completed Form