WEST PLANO PEDIATRICS, P.A.

Patient Information

Last Name ____________ First ____________ Middle ____________ Date of Birth ________ Male / Female

Address ____________________ Apt. # ______ City ____________ State ______ Zip ________

Home Phone (____) ____________________ Referred By: ____________________

Other Children Information

Last Name ____________ First ____________ Middle ____________ Date of Birth ________ Male / Female

Last Name ____________ First ____________ Middle ____________ Date of Birth ________ Male / Female

Last Name ____________ First ____________ Middle ____________ Date of Birth ________ Male / Female

Last Name ____________ First ____________ Middle ____________ Date of Birth ________ Male / Female

Parent Information

Mother's Name ____________________ Work Phone (____) ____________ Cell Phone (____) ____________

Address, if different ____________________ Date of Birth ____________

Employer ____________________ Employer's Phone (____) ____________

Father's Name ____________________ Work Phone (____) ____________ Cell Phone (____) ____________

Address, if different ____________________ Date of Birth ____________

Employer ____________________ Employer's Phone (____) ____________

Mother's Social Security # ____________ Father's Social Security # ____________

Mother's Driver's License # ____________ Father's Driver's License # ____________

Insurance Information

Please present your insurance card and driver's license to the receptionist so that a copy may be made.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to the attending physician. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by the said insurance. I hereby authorize said assigned to release all information that may be necessary to secure payment.

I understand that I am financially responsible for all charges whether or not paid by said insurance.

A fee of $25.00 will be assessed for no show appointments without 24 hours notice given.

Signed ____________________ Date ____________