

West Plano Pediatrics



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 (____) _____
Mother's Occupation _____ Mother's Date of Birth _____
Mother's Email Address _____ Employer's Phone (____) _____
Father's Name _____ Work Phone (____) _____ Cell Phone (____) _____
Father's Occupation _____ Father's Date of Birth _____
Father's Email Address _____ Employer's Phone (____) _____
Mother's Social Security # _____ Father's Social Security # _____
Mother's Driver's License # _____ Father's Driver's License # _____

Billing Address, if different

Insurance Information

Please present your insurance card and driver's license to the receptionist so that a copy may be made. **Also, please be familiar with your insurance coverage. Some plans will not cover a well-visit if your child is sick, some require a second co-pay or will apply a portion toward your deductible. When we verify your insurance coverage your plan will not give us that information.**

Signed _____ Date _____

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 _____