West Plano Pediatrics

Patient Information

Last Name _____ First _____ Middle _____

Date of Birth _____/_____/_____ Male / Female Referred By: _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Other Children Information

Last Name _____ First _____ Middle _____ Date of Birth ____/____/_____

Last Name _____ First _____ Middle _____ Date of Birth ____/____/_____

Last Name _____ First _____ Middle _____ Date of Birth ____/____/_____

Last Name _____ First _____ Middle _____ Date of Birth ____/____/_____

Parent/Legal Guardian Information

Primary Contact: Last Name _____ First _____ Date of Birth ____/____/_____

Cell Phone: _____-_____-_____ Email Address: _____

Relationship to Patient: _____ Social Security #: _____-_____-_____

Address (if different): _____

Secondary Contact: Last Name _____ First _____ Date of Birth ____/____/_____

Cell Phone: _____-_____-_____ Email Address: _____

Relationship to Patient: _____ Social Security #: _____-_____-_____

Address (if different): _____

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 may have a deductible, will not cover a well-visit if your child is sick, or may require a minimum of 12 months between well-visits for children over the age of two. When we verify your insurance coverage, your plan will not provide our office with this information.**

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 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.

I understand that a fee of up to $50.00 will be assessed for no-show appointments, or appointments not cancelled within 24 hours.

Print Name: _____ Signature: _____ Date: ____/____/_____