A close up of a sign

Description generated with very high confidence

Panda Pediatrics

10824 E Crystal Falls Pkwy STE 201

Leander, TX 78641

P:512-528-6100 F:512-528-6200

**Patient Registration Form**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date: | | | | | PCP: | | | |
| How did you hear about us: | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | |
| Patient’s Last Name: | | | First: | | | | Middle: | |
| Nickname: | | | Date of Birth: | | | | Sex: | |
| Address: | | | City, State & Zip Code: | | | | | |
| Lives with: | | | | | | | | |
| **GUARANTOR (PARENT HOLDING INSURANCE))** | | | | | | | | |
| **Primary Ins Co. Name:** Policy ID:Group No.: | | | | | | | | |
| Health Plan (Circle one): HMO PPO HSA Other: Copay: | | | | | | | | |
| Guarantor’s Last Name: | | | First: | | | | Middle: | |
| Relation to Patient: | | | | Date of Birth: | | | | |
| Address (if different): | | | | | | | | |
| Home Phone: | Mobile Phone: | | | | | Email: | | |
| Employer: Work Phone: | | | | | | | | |
| If you have a **secondary insurance**, please notify the front desk. | | | | | | | | |
| **PARENT or GUARDIAN INFORMATION** | | | | | | | | |
| Parent 1 Name: | | DOB: | | | | Relation to Patient: | | |
| Occupation: | | Phone: | | | | Email: | | |
| Parent 2 Name: | | DOB: | | | | Relation to Patient: | | |
| Occupation: | | Phone: | | | | Email: | | |
| **SIBLINGS AT THIS PRACTICE** | | | | | | | | |
| Name: | | Date of Birth: | | | | | | Sex: |
| Name: | | Date of Birth: | | | | | | Sex: |
| Name: | | Date of Birth: | | | | | | Sex: |
| **PHARMACY INFORMATION** | | | | | | | | |
| Preferred Pharmacy: | | | | Phone: | | | | |
| Address: | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | |

The following people are authorized to bring my child for any treatment and may sign informed consent forms in my absence.

|  |  |  |
| --- | --- | --- |
| Name: | Relationship to Patient: | Phone: |
| 1) |  |  |
| 2) |  |  |

Other important information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment and Medication History Release**

I hereby give my consent to Panda Pediatrics and authorize them to provide medical treatment to my child. I also authorize Panda Pediatrics to retrieve my child’s medication history.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Receipt of Notice of Privacy Practices**

I have reviewed this office’s Notice of Privacy Practices, which explains how medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature Parent Printed Name Date