

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.

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Parent Signature Parent Printed Name Date