Patient Registration Form

Panda Pediatrics
10824 E Crystal Falls Pkwy STE 201
Leander, TX 78641
P:512-528-6100 F:512-528-6200

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