



# Patient Registration Form

Panda Pediatrics  
2006 S. Bagdad Rd Ste.150  
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)

Please give your insurance card to the receptionist.

Guarantor's Last Name:	First:	Middle:	
Relation to Patient:	Date of Birth:		
Address (if different):			
Home Phone:	Mobile Phone:	Email Address:	
Insurer:	Policy ID:	Group No.:	Co-pay:
Health Plan (Circle one): HMO PPO HSA Other:			

## OTHER PARENT (NOT HOLDING INSURANCE)

Last Name:	First:	Middle:
Relation to Patient:	Date of Birth:	
Address (if different):		
Home Phone:	Mobile Phone:	Email Address:

## 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)		
3)		

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

## Consent for Treatment

I hereby give my consent to Panda Pediatrics and authorize them to provide medical treatment to my child

## 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