PediPlace
MAKING HEALTHCARE A REALITY FOR EVERY KID

502 S. Old Orchard Ste 126
Lewisville, TX 75067
972.436.7962

Patient Registration

Insurance card and driver's license are required upon each visit at check-in.

Last Name_____ First Name_____

Street Address_____ City_____ Zip Code_____

Date of Birth ___/___/___ Age___ Gender: M/F

To plan for the support and development of a healthcare system that meets the current and future needs of our patients, we ask for the following information: **Please circle**

Ethnicity: Hispanic Non-Hispanic **Preferred Language**: _____

Race:

American Indian or Alaska Native	Asian (includes Pakistan or Indian origins	Black or African American	Hawaiian	Hispanic or Latino (All Races)	Indian
Multiracial	Native Hawaiian	Other Pacific Islander (Not Hawaiian)	Other Race	White	

Parent/Guardian Information

Last Name_____ First Name_____ Middle Initial_____

Date of Birth ___/___/___ Cell Phone_____ Alternate Phone_____

Street Address_____ City_____ Zip Code_____
Marital Status: Married/Single/Divorced/Separated

Spouse or Other Guardian Information

Last Name_____ First Name_____ Middle Initial_____

Date of Birth ___/___/___ Cell Phone_____ Alternate Phone_____

Street Address_____ City_____ Zip Code_____
Marital Status: Married/Single/Divorced/Separated
****Please circle who this patient lives with Mom Dad Both Other _____**

Assignment of Benefits

I authorize my insurance benefits to be paid directly to PediPlace. I understand that if my Medicaid or CHIP is not in effect or my PCP is not correct I am financially responsible for any balance. I also authorize PediPlace or my insurance company to release any information required to process my claims.

Parent Signature: _____ Date: _____

Fax 972.420.0085