



Patient Information

Name: _____ Middle: _____ Last: _____ Suffix: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ - _____ - _____ Sex: M / F DOB: ____ / ____ / ____
 How did you find out about Pediatric Associates of Wylie, P.A.? _____

Primary Guarantor Information & Insurance

Name: _____ Middle: _____ Last: _____ Suffix: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ - _____ - _____ Sex: M / F DOB: ____ / ____ / ____
 Marital Status: _____ Relationship to Patient: _____
 Employment Status: _____ Employer: _____
 Phone: _____ Work: _____ Mobile: _____
 Email: _____
 Insurance Company: _____
 Insurance Company Address: _____ City: _____ State: _____ Zip: _____
 Subscribers I.D. #: _____ Group #: _____
 Insurance Company Phone Number: _____

(Please provide your ID card with this information)

Parent / Guardian Information

Parent / Guardian #1: (If different than Guarantor Information)

Relationship to Patient: _____
 Name: _____ Middle: _____ Last: _____ Suffix: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ - _____ - _____ Sex: M / F DOB: ____ / ____ / ____
 Marital Status: _____ Relationship to Patient: _____
 Employment Status: _____ Employer: _____
 Phone: _____ Work: _____ Mobile: _____
 Email: _____

Parent / Guardian #2: (If different than Guarantor Information)

Relationship to Patient: _____
 Name: _____ Middle: _____ Last: _____ Suffix: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ - _____ - _____ Sex: M / F DOB: ____ / ____ / ____
 Marital Status: _____ Relationship to Patient: _____
 Employment Status: _____ Employer: _____
 Phone: _____ Work: _____ Mobile: _____
 Email: _____

Emergency Contact

Name: _____ Middle: _____ Last: _____ Suffix: _____
Address: _____ City: _____ State: _____ Zip: _____
Is above Emergency contact a Parent / Guardian? Yes / No Sex: M / F
Phone: _____ Work: _____ Mobile: _____
Email: _____

Assignment and Release

I hereby authorize payment directly to Dr. Nicole L. Lanman, Pediatric Associates of Wylie, P.A. of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____