Western Wake Pediatrics, PA

PATIENT INFORMATION

Chart #___________

Patient: ____________________ ____________________ _______ DOB: ____________
Last Name First Name Middle Initial

SIBLING INFORMATION:

____________________ ____________________ _______ ______________ ___________
Last Name First Name Middle Initial DOB Chart #

____________________ ____________________ _______ ______________ ___________
Last Name First Name Middle Initial DOB Chart #

____________________ ____________________ _______ ______________ ___________
Last Name First Name Middle Initial DOB Chart #

____________________ ____________________ _______ ______________ ___________
Last Name First Name Middle Initial DOB Chart #

Address: ____ Home Phone: _______________
____

Father: ____________________ ____________________ ________ DOB: ____________
Last Name First Name Middle Initial SS# ____________

Address: ____ Home Phone: _______________
____ Cell Phone: _______________
Work Phone: _______________

Employer Name: __________________________ Occupation: ____________________________

Mother: ____________________ ____________________ _______ DOB: ____________
Last Name First Name Middle Initial SS# ____________

Address: ____ Home Phone: _______________
____ Cell Phone: _______________
Work Phone: _______________

Employer Name: ____________________________ Occupation: ____________________________

INSURANCE INFORMATION- PLEASE PRESENT CURRENT CARD

Primary Insurance Company: _______________________________________
ID# ________________________ Group # ________________
Subscriber Name: ____________________ ____________________ _______
Last Name First Name Middle Initial
Relationship to Patient: _________________

Secondary Insurance Company: _______________________________________
ID# ________________________ Group # ________________
Subscriber Name: ____________________ ____________________ _______
Last Name First Name Middle Initial
Relationship to Patient: _________________

EMERGENCY CONTACT (Other than Parent)

____________________	____________________	_______	Home Phone: _______________
Last Name	First Name	Middle Initial	Alternate Phone: _______________

Relationship to Patient: _________________

In the absence of the parent/legal guardian, I give the following person(s) to seek treatment for my child/children. I also realize that the person with my child may have access to pertinent protected health information if medically necessary. This authorization will be valid for one year from the date listed below, or until revoked by parent or legal guardian.

________________________________	____________	__________________
Person's Name	Phone #	Relationship
________________________________	____________	__________________
Person's Name	Phone #	Relationship

Signature of Parent/Guardian: ________________________ Date: ____________

I the patient/parent/guardian give Western Wake Pediatrics permission to release information to my daycare/school upon request. Ex: Immunization record, dispensing of medication, and or absentee note due to appointment.

Signature of Parent/Guardian: ________________________ Date: ____________

Payment is expected at the time services are rendered. In the event that the bill remains unpaid and litigation ensues for collection of sums due, this office shall be entitled to reasonable attorney fees and court costs. Please feel free to discuss any and all professional fees with this office. Please sign if you agree to our office policy and wish to be seen.

In the event that Western Wake Pediatrics files a claim on my behalf, I authorize all benefits to be paid directly to Western Wake Pediatrics. Any charges not covered by my insurance will be the responsibility of the guarantor on the account. I authorize Western Wake Pediatrics to release all information required by my insurance company to file for medical benefits on the patient's behalf.

Signature of Parent/Guardian: ________________________ Date: ____________