WELLSTAR Medical Group

PEDIATRIC PATIENT INFORMATION

(Please Print)

Patient's Full Name _____ **Nickname**_____
First Middle Last

Date of Birth _____/_____/_____ ☐ **Male** ☐ **Female** **Social Security Number** _____-_____-_____

Race: _____ **Religion:** _____**Primary Language:** _____ **Primary Care Provider:** ☐ **Lori S. Corley, M.D. or** ☐ **Daniel Saade, M.D.**

Address _____
Street Apartment# City State Zip code

Home # _____ **Cell #** _____ **Email** _____

Patient Lives with: Mom _____ **Dad**_____ **Both Parents** _____ **Other** _____

Pharmacy: _____ **Address:** _____ **Phone#** _____

Individual to contact in an Emergency: _____
(Please list someone not in your household) First Middle Last

Relationship to patient _____ **Home #** _____ **Work #** _____**Cell #** _____

RESPONSIBLE PARTY *(Individual to receive bills after insurance has paid)* ☐**Mother** ☐**Father** ☐**Other** _____

Full Name: _____ **Marital Status:**_____ **Date of Birth:** _____/_____/_____
First Middle Last

Social Security Number _____-_____-_____ **Home #** _____ **Cell #** _____ **Work #** _____

Address _____
Street Apartment# City State Zip code

Mother's Information **Full Name:** _____**Marital Status:**_____ **Date of Birth:** _____/_____/_____
(If not listed above) First Middle Last

Social Security Number _____-_____-_____ **Home #** _____ **Cell #** _____ **Work #** _____

Address _____
Street Apartment# City State Zip code

Father's Information **Full Name:** _____ **Marital Status:**_____ **Date of Birth:** _____
(If not listed above) First Middle Last

Social Security Number _____-_____-_____ **Home #** _____ **Cell #** _____ **Work #** _____

Address _____
Street Apartment# City State Zip code

INSURANCE POLICY HOLDER INFORMATION **If Policy Holder is:** ☐ **Account Holder (Skip this section) (Please submit your card(s) to be scanned)**

Full Name: _____ **Relationship to Patient:** _____ ☐ **Male** ☐ **Female**
First Middle Last

Social Security Number _____-_____-_____ **Date of Birth** _____ **Marital Status** _____

Address _____
Street Apt# City State Zip code

Home # _____ **Cell #** _____ **Work #** _____

Assignment of Benefit/Consent for Treatment: I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians.

Signature of Parent or Legal Guardian: _____ **Date:** _____

(Rev. 8/25/14 dg)