2017 LAURELWOOD PEDIATRICS PATIENT INFORMATION

☐**New Patient** ☐**Established Patient**

Please list all children who are patients at Laurelwood

	NAME	NICKNAME	GENDER	DOB	Primary Physician
1.	_____	_____	_____	_____	☐ Lana Yanishevski
2.	_____	_____	_____	_____	☐ Chris Hanson
3.	_____	_____	_____	_____	☐ Ashley Miller
4.	_____	_____	_____	_____	☐ Joel Siegel
					☐ Nouth Magdovitz

PARENT / LEGAL GUARDIAN

Name _____

Birth Date_____ **SSN** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone: H _____ **C** _____ **W** _____

Employer _____

Email Address _____

PARENT / LEGAL GUARDIAN

Name _____

Birth Date_____ **SSN** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone: H _____ **C** _____ **W** _____

Employer _____

Email Address _____

If this is your first visit with us, whom may we thank for the referral? _____

Emergency Contact Information

Name _____ **Relationship** _____ **Phone** _____

PRIMARY INSURANCE INFORMATION

Insurance Carrier _____

Policy # _____ **Group #**_____

Policy Holder's Name _____

Policy Holder's Birthdate _____

Do your children have TennCare? _____

GENERAL CONSENT AUTHORIZATION

People authorized to consent for medical treatment (step-parents, grandparents, aunts, etc.)

1. _____
   Name/Relationship to patient
2. _____
   Name/Relationship to patient

I hereby authorize Laurelwood Pediatrics, LLC to furnish information to my insurance carrier concerning any treatment/illness/accident, and hereby irrevocably assign to the doctor all payments for medical services rendered to me. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I also understand that I am responsible for any reasonable costs and / or attorney fees incurred for the collection of this account. Our policy is payment at the time of service.

_____ _____ _____

Parent / Guardian Signature **Printed Name** **Date**