

**2019**

# LAURELWOOD PEDIATRICS PATIENT INFORMATION

New Patient     Established Patient

Please list all children who are patients at Laurelwood

	<u>NAME</u>	<u>NICKNAME</u>	<u>GENDER</u>	<u>DOB</u>	<u>Who's your Primary Doctor?</u>
1.	_____	_____	_____	_____	<input type="checkbox"/> Dr. Lana Yanishevski
2.	_____	_____	_____	_____	<input type="checkbox"/> Dr. Chris Hanson
3.	_____	_____	_____	_____	<input type="checkbox"/> Dr. Ashley Miller
4.	_____	_____	_____	_____	<input type="checkbox"/> Dr. Joel Siegel
					<input type="checkbox"/> Dr. Nouth Magdovitz

**PARENT / LEGAL GUARDIAN**

**PARENT / LEGAL GUARDIAN**

Name \_\_\_\_\_

Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phones: Home \_\_\_\_\_ Cell \_\_\_\_\_

Phones: Home \_\_\_\_\_ Cell \_\_\_\_\_

Work \_\_\_\_\_

Work \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Email Address \_\_\_\_\_

Email Address \_\_\_\_\_

If this is your first visit with us, who may we thank for the referral? \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

**GENERAL CONSENT AUTHORIZATION**

Insurance Carrier \_\_\_\_\_

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

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

1. \_\_\_\_\_  
Name/Relationship to patient

Policy Holder's Name \_\_\_\_\_

2. \_\_\_\_\_  
Name/Relationship to patient

Policy Holder's Birthdate \_\_\_\_\_

Do your children have TennCare? \_\_\_\_\_

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