# 2019 LAURELWOOD PEDIATRICS PATIENT INFORMATION

☐New Patient ☐Established Patient

**18 Years of Age and Older**

**Who's your Primary Doctor?**

☐ Dr. Lana Yanishevski
☐ Dr. Chris Hanson
☐ Dr. Ashley Miller
☐ Dr. Joel Siegel
☐ Dr. Nouth Magdovitz

Name ________________________________ Nickname ___________________

Date of Birth ________________ Gender: M / F (Circle one)

Phones: (Please indicate the best number to reach you)

□ Home _____________________ □ Cell ______________________

□ Work ______________________

Address ____________________________________________________________________

City ___________________________________ State _________ Zip __________________

Employer________________________________ Email ______________________________

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## Parent/Guardian Information

Name ______________________________ Relationship __________________________ Phone _____________________

Name ______________________________ Relationship __________________________ Phone _____________________

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**PRIMARY INSURANCE INFORMATION**

Insurance Carrier ____________________________

Policy # __________________ Group # ___________

Policy Holder's Name __________________________

Policy Holder's Birthdate _____________________

Do you have TennCare? ________________________

**RELEASE OF MEDICAL INFORMATION**

Please list the names of the individuals we may release medical information to. Mark the appropriate medical information boxes indicating what we may release.

☐Labs including HIV and STDs
☐Prescription refills and pick up of written prescriptions
☐Billing
☐Mental health records
☐Phone Messages
☐All my health information including those listed above

Name____________________________________________

Name____________________________________________

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.

_______________________________________ _____________________________________ ___________

Patient Signature Printed Name Date