

2012

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>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

PARENT / LEGAL GUARDIAN

PARENT / LEGAL GUARDIAN

Name _____

Name _____

Birth Date _____ SSN _____

Birth Date _____ SSN _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Phone: Home _____ Cell _____

Phone: Home _____ Cell _____

Employer _____ Work _____

Employer _____ Work _____

Email Address _____

Email Address _____

Do your children have TennCare? _____

Emergency contact information

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE INFORMATION

GENERAL CONSENT AUTHORIZATION

Insurance Carrier _____

Name of Individual(s)

Authorized to consent for medical treatment (i.e., grandparents, aunts, etc.)

Policy Holder's Name _____

1. _____
Relationship to patient

Policy Holder's DOB _____

2. _____
Relationship to patient

AUTHORIZATION: I hereby authorize Laurelwood Pediatrics, LLC to furnish information to my insurance carrier concerning this 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 covered by insurance. I also understand that I am responsible for 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 _____

Date _____

Received by: _____

Parent/Guardian: Please print your name above _____

Verified by: _____