2024 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: Home _________________ Cell _________________

Work _________________

Employer ____

Email Address ______________________________________

PARENT / LEGAL GUARDIAN

Name ____

Birth Date___________ SSN _________________________

Address ____

City _____________________ State _____ Zip ___________

Phone: Home _________________ Cell _________________

Work _________________

Employer ____

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

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