WESTERN WAKE PEDIATRICS

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Fax (919) 859-6595
www.wwpeds.com

PATIENT INFORMATION **Date: _____**

(*Please list ALL children in the family that are patients at this office ages 17 and under.*)

	Child 1	Child 2	Child 3	Child 4
Last Name				
First Name				
Middle Name				
DOB				
Male or Female				
Preferred Name				
Ethnicity				

PARENTAL INFORMATION

LEGAL GUARDIAN
Name _____

☐ **Mother** ☐ **Father** ☐ **Other:** _____
DOB _____ SSN# _____
Mailing Address _____
City _____**State**_____ **Zip Code**_____
Cell Phone _____
Alternate Phone _____
Employer _____
Marital Status: ☐Single ☐Married ☐Together not married ☐Divorced ☐Widowed
Preferred Language _____
☐ **Step Parent** [IF applicable]

LEGAL GUARDIAN **☐check if SAME address**
Name _____
☐ **Mother** ☐ **Father** ☐ **Other**: _____
DOB _____ SSN# _____
Mailing Address _____
City_____ **State**_____ **Zip Code**_____
Cell Phone _____
Alternate Phone _____
Employer _____
Marital Status: ☐Single ☐Married ☐Together not married ☐Divorced ☐Widowed
Preferred Language _____
☐**Step Parent** [IF applicable]

Who do the children reside with? ☐ Father ☐ Mother ☐ Both ☐ Other_____

Who has legal custody of the child/children? ☐ Father ☐ Mother ☐ Both ☐ Other _____
Please provide any applicable legal documents.

Who is responsible for the medical bills? ☐ Father ☐ Mother ☐ Other _____
Which phone # should we list as your primary contact? _____ Is it ok to leave a message at this #? _____
What is your preferred method of communication?

☐ Phone _____ ☐ Email _____

INSURANCE INFORMATION

****PLEASE NOTE: YOU MAY BE ASKED TO PRESENT YOUR INSURANCE CARD AT EVERY VISIT****

PRIMARY INSURANCE
Insurance Company _____
Member/Subscriber# _____
Group # _____
Issue/Effective Date _____
Employee's Name _____
Employee's DOB _____
Employer _____

SECONDARY INSURANCE
Insurance Company _____
Member/Subscriber # _____
Group # _____
Issue/Effective Date _____
Employee's Name _____
Employee's DOB _____
Employer _____

EMERGENCY CONTACT (Other than Parent)- If applicable
Name _____ Relationship _____
Cell Phone _____

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____

How did you hear about us? □ Internet search □ Facebook/Instagram □ Friend/Family/Neighbor □ Other Physician