Poole Pediatrics, P.A.

Date: _____ ***** **PATIENT INFORMATION:******

Last Name: _____First Name: _____Middle Name: _____Sex: _____DOB_____

Last Name: _____First Name: _____Middle Name: _____Sex: _____DOB_____

Last Name: _____First Name: _____Middle Name: _____Sex: _____DOB_____

Ethnicity: (Please select all that apply):
American Indian ___ Asian ___ African American ___ Hispanic or Latino ___
Pacific Islander ___ Caucasian ___ Other _____

PARENT/GUARDIAN INFORMATION: **Preferred Contact Phone Number (PLEASE CIRCLE ONE): Home Cell Work**

Father's/Guardian's Last Name: _____ First Name: _____

Date of Birth: _____ SS # _____-_____-_____ Marital Status: Single _____ Married _____ Divorced _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Email address: _____

Mother's/Guardian's Last Name: _____ First Name: _____

Mother's Maiden Name: _____ Email address: _____

Date of Birth: _____ SS # _____-_____-_____ Marital Status: Single _____ Married _____ Divorced _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

*******Preferred Contact Phone Number (PLEASE CIRCLE ONE): Home Cell Work**

PREFERRED PHARMACY – ELECTRONIC PRESCRIBING ENROLLMENT:

Pharmacy Name: _____ Phone: _____ Fax: _____

Address: _____City: _____Cross Streets: _____

INSURANCE INFORMATION:

Insurance Company: _____Employer'sName_____

Primary Insured's Last Name: _____First Name: _____
**It is your responsibility to provide our office with any changes in insurance policy information.

ASSIGNMENT OF BENEFITS AND CONSENT TO TREAT

I hereby authorize the release of any medical information necessary to process an insurance claim and assign payment to be made directly to the physician. **I understand I am financially responsible for any fees incurred regardless of the status of my insurance claims; this includes fees for medical services not covered by insurance**. As parent/guardian of above patient, I consent to treatment of said patient. A photocopy of this assignment is to be considered as valid as an original.

Signed: _____ Date: _____

Printed Name_____Relationship to Patient:_____