Pediatric Associates of West Tennessee, PLLC
1501 Brayton Avenue
Dyersburg, TN 38024

Patient Information

Child's Name:_____M_____F_____ Age_____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____
Child's Social Security Number: _____ Race: _____
Language:_____ Ethnicity: _____ Pharmacy: _____
Email Address:_____

FATHER'S INFORMATION

Father's Name: _____ SS#:_____DOB: _____
Father's Address: _____
Father's Home Phone: _____ Father's Cell Phone: _____
Father's Employer Name: _____ Work Phone:_____
Father's Employer Address: _____

MOTHER'S INFORMATION

Mother's Name: _____ SS#: _____ DOB: _____
Mother's Address: _____
Mother's Home Phone: _____ Mother's Cell Phone: _____
Mother's Employer Name: _____ Work Phone: _____
Mother's Employer Address: _____

GUARDIAN INFORMATION (IF APPLICABLE)

Guardian Name: _____ SS# _____ DOB: _____
Guardian Address: _____
Guardian Home Phone: _____ Guardian Cell Phone: _____
Guardian Employer Name: _____ Work Phone: _____
Guardian Employer Name: _____

EMERGENCY CONTACT (Someone other than Parent/Guardian)

Name: _____
Address: _____
Home Phone: _____Cell Phone:_____ Work Phone:_____

INSURANCE INFORMATION

WE WILL FILE YOUR HEALTH INSURANCE; HOWEVER, YOU WILL RECEIVE MONTHLY STATEMENTS. AT EACH VISIT YOU ARE RESPONSIBLE FOR PAYING CO-PAYS, DEDUCTIBLES AND BALANCE DUE, AFTER INSURANCE. YOU ARE RESPONSIBLE FOR PROMPTLY RESPONDING TO ALL INSURANCE INQUIRIES.

	(1)	(2)
Insurance Company:		
Address:		
ID/Policy Number:		
Group/Plan Number:		
Insured's DOB:		
Name of Insured:		

I accept personal responsibility for payment of the charges for services rendered to my child. I authorize payment of medical insurance benefits to Pediatric Associates of West Tennessee, PLLC. I also authorize the release of my insurance company, or attorney any information required including diagnosis and records.

Date: _____ Signature: _____