WHITE'S PEDIATRICS

Patient Information

Last Name		First Name		MI	
Nickname		DOB		Sex	M F
SSN		Phone #			
Address			City, Zip		

Patient Lives With	☐ Mother ☐ Father ☐ Both ☐ Other ______________________________
Preferred Language	☐ English ☐ Spanish ☐ Other _________________________________
Ethnicity	☐ Hispanic ☐ Non-Hispanic	Race _________________________________
Preferred Provider	☐ Dr. White ☐ Dr. Tull ☐ Dr. Jordan ☐ Dr. Wang

☐ Carey Bramlett ☐ Kathy Schleier ☐ Buffy Mosteller ☐ Kelly Cline ☐ Regina Rogers

Parent / Guardian Information

Last Name		First Name		DOB	
Relationship to Patient					
Address			City, Zip		
Employer			SSN		
Contact Information	Home # ________________________ Cell #__________________________ Email ______________________________________				
Preferred Contact Method	☐ Phone Call ☐ Text Message ☐ Email ☐ Patient Portal				
Last Name		First Name		DOB	
Relationship to Patient					
Address			City, Zip		
Employer			SSN		
Contact Information	Home # ________________________ Cell #__________________________ Email ______________________________________				
Preferred Contact Method	☐ Phone Call ☐ Text Message ☐ Email ☐ Patient Portal				
Guarantor	The person signing this form will be noted in our records as the "guarantor" of the account, and will receive billing statements from our office. We understand that parents may have developed financial/legal arrangements regarding responsibility for medical care. We request that these arrangements be coordinated between the parents and that a copy of any legal documents regarding these arrangements be provided to our office.				

Please list below any additional persons who may bring the child to appointments, or who we are authorized to communicate with regarding visits, medical information, etc.

Name		Relationship		Phone #	
Name		Relationship		Phone #	
Name		Relationship		Phone #	
Name		Relationship		Phone #	

Insurance Information (Please present your insurance card & driver's license to the receptionist)

Primary Insurance		Policyholder's Name	
Policyholder's DOB		Policyholder's SSN	

Other Children in the Family

Name		DOB		Relationship	
Name		DOB		Relationship	
Name		DOB		Relationship	
Name		DOB		Relationship	

- I consent to all treatment necessary for the care of the above-named patient.
- I understand that payment of charges incurred is due at the time of service unless other financial arrangements have been made prior to treatment.
- I accept full financial responsibility for services rendered by any White's Pediatrics provider. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations. I agree to pay all reasonable attorney's fees and collection costs in the event of default of payment of my charges.

Print Name ___________________________ Relationship to Patient _________________________________

Signature ____ Date ____________________