Patient Information

First Name		Last Name		Nickname	
DOB		Patient Lives With	□ Mother □ Father □ Both □ Other		
Address			Sex	M F	
City, Zip		Preferred Language			
SSN		Ethnicity	□ Hispanic □ Non-Hispanic	Race	
Preferred Provider	□ Dr. White □ Dr. Point du Jour □ Dr. Ezeoke				
□ Carey Bramlett □ Ashley Blevins □ Buffy Mosteller □ Kelly Cline □ Regina Rogers □ Laura Brown					
Is the patient 18 or older?	Y N				

Parent / Guardian #1 Information

First Name		Last Name	
DOB		SSN	
Relationship to Patient			
Address			
City, Zip			
Email			
Phone	Home # _____ Cell #_____		
Preferred Contact Method	□ Phone Call □ Text Message □ Email □ Patient Portal		
Employer			
Employer Address			
Employer Phone			

Parent / Guardian #2 Information

First Name		Last Name	
DOB		SSN	
Relationship to Patient			
Address			
City, Zip			
Email			
Phone	Home # _____ Cell #_____		
Preferred Contact Method	□ Phone Call □ Text Message □ Email □ Patient Portal		
Employer			
Employer Address			
Employer Phone			

Other Children in the Family

Name			
Relationship		DOB	
Name			
Relationship		DOB	
Name			
Relationship		DOB	

Insurance Information (Please present your insurance card & driver's license to the receptionist)	
Primary Insurance	
Policyholder's Name	
Policyholder's SSN	
Policyholder's DOB	
Secondary Insurance	
Policyholder's Name	
Policyholder's SSN	
Policyholder's DOB	

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

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

Guarantor Policy

Whomever signs this form will be noted in our records as the "guarantor" of the account, and will receive billing statements from our office. We require patients 18 or older to sign the form themselves; their parent/guardian may also sign the form if they so desire. We understand that divorced 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 note that even if a parent/guardian gives someone else permission to bring a child in for an appointment, the parent/guardian whose signature is on this form will be the one responsible for payment of the services provided.

Consent & Agreement

By signing below, I/we consent to all treatment necessary for the care of the above-named patient. I/we understand that payment for services is due in full at the time service is provided, and that I/we will be billed in accordance with the Guarantor Policy written above. In the event this account is delinquent and placed with a collection agency, I/we will be responsible for the collection fee of 30% of the account balance as liquidated damages, and if an attorney is hired to collect, after maturity, 15% of unpaid principal and interest owing on said account as attorney's fees.

Print Name _____

Relationship to Patient _____

Signature _____ Date _____

Print Name _____

Relationship to Patient _____

Signature _____ Date _____

Signature of Patient (if 18 or older _____ Date _____