

THOMASVILLE PEDIATRICS

200 Arthur Drive • Thomasville, N.C. 27360
Phone: (336) 475-2348 • Fax: (336) 475-2100

PATIENT INFORMATION

PLEASE FILL OUT EACH LINE ON THIS ENTIRE FORM

PATIENT _____ (_____)
(Full Name) (Last) (First) (Middle) (Name Called)

Address _____

Home Phone# () _____ E-Mail _____

Date of Birth _____ Place of Birth _____

Social Security # _____ Sex (circle one): M F

FAMILY

Person Responsible for Account (one person) _____

Address _____

Have we seen other children in your family? YES NO

Name of other children _____

Father's Name _____ Date of Birth _____
(Full Name) (First) (Middle) (Last)

Address _____

_____ Social Security # _____

Place of Work _____ Phone # () _____

Address _____

Mother's Name _____ Date of Birth _____
(Full Name) (First) (Middle) (Last)

Address _____

_____ Social Security # _____

Place of Work _____ Phone # () _____

Address _____

Emergency Contact Name _____ Phone # () _____

INSURANCE

Primary Insurance Company _____

Policy Number _____ Group # _____

Name of Policy Holder _____

Secondary Insurance Company _____

Policy Number _____ Group # _____

Name of Policy Holder _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO THOMASVILLE PEDIATRICS, I hereby authorize the physician designated to release information acquired in the course of my examination and treatment. I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number. With my signature on this form, I authorize and consent to the release of my (or my child's) medical records to Thomasville / Archdale-Trinity Pediatrics. I understand and agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

SIGNATURE _____ DATE: _____

(Parent or Guardian, if Patient is a Minor)