Poole and Thomas Pediatrics, PLC
2351 Huguenard Drive
Suite 200
Lexington, KY 40503
859-260-7700

Information about our Patient:

First Name _____Middle Initial_____ Last Name_____

Primary Email Address _____

Childs Preferred Name _____ Date of Birth _____Sex _____

Primary Phone Number: _____ Cell _____ Other_____

Siblings: Last Name, First Name, Middle Initial	Date Of Birth: Male Or Female (Circle)	Child's Preferred Name:
	Male Or Female (Circle)	
	Male Or Female (Circle)	
	Male Or Female (Circle)	
	Male Or Female (Circle)	

Parent/Legal Guardian Information:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip_____

Place of Employment: _____ Occupation: _____

Relationship to Patient _____ Date of Birth _____ SS#_____

Additional Parent/Legal Guardian Information:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip_____

Place of Employment: _____ Occupation: _____

Relationship to Patient _____ Date of Birth _____ SS#_____

Insurance _____Policy Holder_____

Please let us know who referred you to our office: _____

Please be aware that our Financial Policies are available on line at www.ptpediatrics.com or you may ask for a copy in the office. By signing below, I authorize medical treatment and payment of medical benefits for any services rendered by Poole and Thomas Pediatrics, PLC. I assume all responsibility for charges and authorize the release of any medical information needed to process any claim. I permit a copy of this authorization to be used in place of the original.

Authorized Parent Signature _____ Date_____