Poole&Thomas
personal pediatric care

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Childs Preferred Name: _____ Date of Birth: _____ Sex: _____

Primary Email Address: _____

Primary Phone Number: _____ Cell: _____ Other: _____

Best Phone Number to Send Text Reminders/Notifications: _____ Okay to leave messages? YES ☐ NO ☐

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 Number: _____

Additional Parent/Legal Guardian Information:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Place of Employment: _____ Occupation: _____

Relationship to Patient: _____ Date of Birth: _____ SS Number: _____

Insurance: _____ Insured ID: _____

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:** _____