Duane M. Wooten, MD, PC

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NEW PATIENT INFORMATION RECORD

PATIENT'S NAME (FIRST, M.I., LAST):		DATE OF BIRTH:	SEX:	ETHNICITY/RACE:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:	
HOME PHONE #:	EMERGENCY CONTACT NAME, RELATIONSHIP, AND PHONE #:			
PHARMACY NAME, ADDRESS, AND PHONE #:				
HOW DID YOU HEAR ABOUT US?:				

PARENT INFORMATION

MOTHER'S NAME (FIRST, M.I., LAST)		DATE OF BIRTH:	SOCIAL SECURITY # (SSN):
STREET ADDRESS (IF DIFFERENT FROM ABOVE):	CITY:	STATE:	ZIP CODE:
MOTHER'S EMPLOYER:	WORK PHONE #:	MOTHER'S EMAIL ADDRESS:	
HOME PHONE #:	CELL PHONE #:	OTHER #:	
FATHER'S NAME (FIRST, M.I., LAST):		DATE OF BIRTH:	SOCIAL SECURITY # (SSN):
STREET ADDRESS (IF DIFFERENT FROM ABOVE):	CITY:	STATE:	ZIP CODE:
FATHER'S EMPLOYER:	WORK PHONE #:	CELL PHONE #:	
EMAIL ADDRESS:			

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT:	PRIMARY INSURANCE NAME:	PRIMARY INSURANCE ADDRESS & PHONE #:
PRIMARY POLICY HOLDER:	PRIMARY POLICY #:	PRIMARY GROUP #:
SECONDARY INSURANCE NAME:	SECONDARY INSURANCE ADDRESS & PHONE #:	
SECONDARY POLICY HOLDER:	SECONDARY POLICY #:	SECONDARY GROUP #:

I hereby authorize Rainbow Pediatrics and/or Dr. Duane M. Wooten to furnish information to insurance carriers concerning illness and/or accident. I hereby authorize Rainbow Pediatrics and/or Dr. Duane M. Wooten to receive payment for medical services as rendered. I also authorize, the release of any medical information necessary to process medical claims. A photocopy of this authorization will be as valid as the original. I understand I am financially responsible for all charges whether or it they are covered by the insurance.

RESPONSIBLE PARTY'S NAME (PRINTED) _____ RESPONSIBLE PARTY'S SIGNATURE _____ DATE _____