OLDHAM COUNTY PEDIATRICS, PLLC

Joshua Honaker, MD Diane Wetherton, MD Ashli Collins, MD Greg Robson, MD
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PATIENT INFORMATION

Name: _____ _____ _____ _____
(last) (first) (MI) "Call me"

Date of Birth:_____ Gender: Male / Female SS#_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Alternate Phone#:_____

Parents' Names:_____

Siblings: _____

_____

Emergency Contacts Phone #'s Relationship to Patient

1._____

2._____

Guarantor/Responsible Party Information

Guarantor:_____ Relationship to patient: _____

Guarantor's Date of Birth:_____ Social Security #:_____

Address:_____ City_____ State_____ Zip _____

Guarantor's Employer:_____ Phone:_____

Primary Insurance Information

Insurance Company:_____

Insurance Co. Address:_____ City_____ State ____ Zip_____

Insurance Co. Phone #:_____

Policy Owner:_____ Relationship to Patient:_____

Policy Owner's Date Of Birth: _____ Social Security #:_____

Secondary Insurance?_____

_____

I authorize the release of medical information needed to determine any benefits under my insurance policy. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. I consent to routine treatment and procedures provided by Oldham County Pediatrics, PLLC, and understand that no guarantee of result has been made.

Signature:_____ Date:_____