

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 _____ Age _____
 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# _____

What Insurance will be filed for your visit today? _____

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 _____