Patient Information

First Name _____ Last Name _____ DOB _____/_____/_____

Address _____ Zip_____

Home Phone _____ **Cell Phone** _____

Parent Information: Please list both parents. If only one parent, please put N/A on the second.

Parent #1 _____ DOB____/____/_____ Relationship _____

Address (if different) _____

Home Phone _____ Cell Phone_____ Email _____

Parent #2 _____ DOB____/____/_____ Relationship _____

Address (if different) _____

Home Phone _____ Cell Phone _____ Email _____

Responsible Party: Person to receive statements.

Name _____ DOB_____/____/_____ Relationship _____

Address (if different) _____ Phone _____

Insurance Information

Insurance Name _____ Employer_____ Relationship_____

Subscriber Name _____ DOB____/____/_____ SSN_____

Sibling(s): First and Last Name and DOB (If siblings have different info than listed above, a separate form will need to be completed.)

_____ _____ _____

_____ _____ _____

Emergency Contact: Other than the parent(s) listed above.

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Please read the following statements:

Woods Mill Pediatrics & Adolescent Medicine utilizes a patient appointment reminder system (email, phone call or text message) to confirm your child(ren's) appointment before a prescheduled appointment.

I understand that a 24-hour notice is required to cancel or reschedule appointments; otherwise, there is a $35 missed appointment and late cancellation fee.

Signature_____**Date**_____

Washington University Clinical Associates – Woods Mill Pediatrics

226 S. Woods Mill Rd, 36W, Chesterfield MO 63017

Ph: 314-453-9666 fax: 314-453-9895