WINSTON - SALEM

Pediatrics

PATIENT INFORMATION

Today's date:_____

USUAL PROVIDER:
Circle ONE

BYUN WILEY GARDNER
TODA NAGPAL

LAST NAME of CHILD _____
FIRST NAME of CHILD _____
MIDDLE NAME OR INITIAL _____

DATE OF BIRTH_____

PRIMARY LANGUAGE

ENGLISH SPANISH OTHER
_____

ADDRESS_____
_____

MALE ___ **FEMALE** ___

HOME PHONE _____

MOBILE PHONE _____

WORK PHONE_____

EMAIL : _____

RACE: ALASKAN
ASIAN
BIRACIAL
BLACK/AFRICAN AMERICAN
NATIVE/AMERICAN INDIAN
Hawaiian/Pacific Islander
White/Caucasian
Other_____

ETHNICITY: HISPANIC OR LATINO
NOT HISPANIC OR LATINO
UNKNOWN

HOW DID YOU HEAR ABOUT OUR PRACTICE:
INTERNET FRIEND/FAMILY OTHER _____

COMMUNICATOR AUTOMATED MESSAGING PREFERENCES

HEALTH NOTIFICATIONS: EMAIL PHONE TEXT MESSAGE

APPOINTMENTS: EMAIL PHONE TEXT MESSAGE

ANNOUNCEMENTS: EMAIL PHONE TEXT MESSAGE

BILLING: EMAIL PHONE TEXT MESSAGE

PATIENT CARE SUMMARY : PAPER COPY SENT TO PATIENT PORTAL

PARENT(S) / LEGAL GUARDIAN(S) INFORMATION

Child lives with : Mother _____ Father_____ Parents_____ Other _____

Emergency Contact if parent not available: _____
Relationship to child: _____

Home Phone # _____

Mobile phone # _____

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Mothers name:_____

DOB_____ Social Security # _____ Employer:_____

Address if different from child: _____
_____

Fathers name:_____

DOB_____ Social Security # _____ Employer:_____

Address if different from child: _____
_____

Guarantor Information:

Mail billing statement to: Mothers address _____ Fathers address _____

I authorize my child's providers office to contact me to remind me of my child's appointments and any other communications as needed.

SIGNATURE OR PARENT/LEGAL GUARDIAN

_____ DATE_____

ENTERED BY STAFF:_____ DATE:_____