Wee Care
PEDIATRICS

PATIENT INFORMATION/REGISTRATION

Dr. Stephen West _____ Dr. Ryan Bates _____

Child's Name: _____ Male _____ Female _____

Child's Date of Birth: _____ Expected due date: _____

Address: _____

_____

How did you hear about us?: _____

Did you have a prenatal visit with us? **YES** **NO**

Mother's Name: _____

Father's Name: _____

Home Phone #: _____

Mother's Work #: _____ Father's Work #: _____

Mother's Cell #: _____ Father's Cell #: _____

Email Address: _____

Insurance Company: _____

Policy Number: _____

Certificate Number: _____

Effective Date: _____

Policy Holder: _____

PLEASE NOTE THAT IF WE DO NOT HAVE YOUR CORRECT INFORMATION WE CANNOT SUBMIT YOUR CLAIMS FOR YOU OR REACH YOU IF NEEDED.

CREDIT POLICIES, TERMS AND CONDITIONS

I/We agree to the policies, terms and conditions of Wee Care Pediatrics. I/We agree that all agency charges, legal costs and other expenses incurred by Wee Care Pediatrics in attempting to recover overdue amounts will be charged to my/our account. I/We give permission to Wee Care Pediatrics to obtain information from any source to verify any statement made in this registration form.

Date: _____ Signature: _____