

Haywood Pediatric & Adolescent Associates, P.A.

DATE \_\_\_\_\_

ACCOUNT # \_\_\_\_\_

Please fill out completely!

**Patient's Name** \_\_\_\_\_  
 (Last Name) (First Name) (Middle Name)

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex: Male Female

Race :  American Indian  Asian  Black or African American  More than one race  White  Hispanic or Latino  Prefer not to answer  
 Other: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Prefer not to answer Language Preference: \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 (Mailing Address) (City) (State, ZIP)

Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact: (Check One)  Mother  Father  Other: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Preferred method of communication: appointment reminders, immunization reminders, etc...

- \_\_\_\_\_ Postal Mail
- \_\_\_\_\_ Phone
- \_\_\_\_\_ Web Message through our Patient Portal

Preferred Provider: (please check **ONLY** one)  Dr. Stephen Wall  Dr. Steven Hammel  Dr. Karin McLelland  
 Dr. Trew Stransky  Dr. Sara Evers  Anne Sarzynski  Lillian Norris

**Mother's or Guardian's Full Name** \_\_\_\_\_ Maiden Name \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 (Mailing Address) (City) (State, ZIP)

Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Father's or Guardian's Full Name** \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 (Mailing Address) (City) (State, ZIP)

Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

MORE ON THE NEXT PAGE →

