Dr Joanne Lysack
@Wee Care Pediatrics
7 Elliott St West
Hamilton, Bermuda HM10x
Ph: (441) 542-3995 fax: (441) 296-3035

Patient Name: _____ Male: __ Female: __ Other: __

Date of Birth: _____

Address: _____

Postal Code: _____

Home #: _____ Cell #: _____

Work #: _____

Emergency Name & Contact #: _____

Email (for appointment reminders): _____

Preferred Pharmacy: _____

Insurance Company: _____ Policy Number: _____

Effective Date: _____

Policy holder (spouse, yourself or other):_____

PLEASE NOTE 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: _____