Dr. Stephen West ___ Dr Ryan Bates ___

Child's Name: ____ Male ___ Female ___

Child's Date of Birth: ____________________ Expected Due Date: ______________________

Address: ____

____

Sibling(s) Name(s) & DOB:____

____

Preferred email for appointment reminders: ____

How did you hear about us? ____

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

Preferred Pharmacy: ____

Parent #1

Name: _____________________________ Gender:______ Date of Birth: ________________

Home #: __________________ Cell #: ________________ Work #: __________________

Parent #2

Name: _____________________________ Gender:______ Date of Birth: ________________

Home #: __________________ Cell #: ________________ Work #: __________________

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Insurance Company: __________________ Policy Number: __________________________

Effective Date: _______________________ Policy holder (which parent): ________________

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: ______________________________