Wee Care Pediatrics

Where Compassion, Caring and Dedication Come First

Annual Update Sheet

Child's Name: _____ DOB: _____ M / F SS#:_____

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Ethnicity: ◯ **Non- Hispanic** ◯ **Hispanic** **Race(s):** ◯ **African American** ◯ **Asian** ◯ **Caucasian**

◯ **Native American** ◯ **Pacific Islander** ◯ **Other** ◯ **Refused Preferred Language:** _____

Address: _____ Apt #: _____ City: _____ Zip: _____

Primary Phone: _____ ◯Home ◯Cell Secondary Phone: _____ ◯Home ◯Cell

Primary Ins: _____Member ID: _____ Grp #: _____

Subscriber's Name: _____ SS#: _____DOB: _____

Secondary Ins: _____ Member ID: _____ Grp #: _____

Subscriber's Name: _____ SS#: _____DOB: _____

If you would you like to receive emailed communications from Wee Care Pediatrics, list your email address

_____. We will never share your email address with anyone. Your protected health information will never be disclosed in the email communications and full HIPAA/HITECH guidelines will always be observed.

Treatment Authorization

By signing below, I authorize the following people to bring my/the above listed children in to Wee Care Pediatrics for medical care and treatment. I understand that I may revoke this authorization at any time and it will remain in effect until I do so. If you choose not to authorize any other person(s), please write N/A.

_____ _____

(Name) (Relationship to child)

_____ _____

(Name) (Relationship to child)

I understand that I am responsible for updating my insurance, address or contact information with Wee Care Pediatrics. I understand that account balances, copay and deductibles are due at the time of service. Any account balances that exceed 90 days will be sent to an outside collection agency and I will be responsible for collection and or legal fees. I authorize Wee Care Pediatrics to submit a claim to my health plan on my behalf for payment.

_____/_____/_____ Date: _____

Print (Parent or Guardian) Signature Relationship

4785 S. Durango Dr Ste 101 Las Vegas, NV 89147 P(702)889-8444 Fax (702)889-8454