



WESTERN WAKE WELLNESS, PLLC
PEDIATRIC REGISTRATION

401 KEISLER DRIVE
SUITE 101
CARY NC 27518
919-378-1492
www.WakeWellness.com

PATIENT INFORMATION

Legal Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of birth: ___/___/_____ Age: _____ Sex: Male Female Social Security Number: _____
Home Phone: _____ Nickname: _____ Language: English or other: _____
Mother's Name: _____ Cell Phone: _____ Work Phone: _____
Father's Name: _____ Cell Phone: _____ Work Phone: _____
Email address: _____

Race: White / American Indian or Alaska Native / Asian / Black or African American
Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity: Not Hispanic or Latino / Hispanic or Latino / I Decline to Answer

GUARANTOR INFORMATION (Person Responsible For Bill)

Legal Name: _____ Relationship to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of birth: ___/___/_____ Home Phone: _____ Social Security Number: _____
Employer Name and Address: _____

PRIMARY HEALTH INSURANCE (Please bring card with you)

Insurance Company: _____
Policy ID#: _____ Group#: _____ Effective Date: _____

SECONDARY INSURANCE

Insurance Company: _____
Policy ID#: _____ Group#: _____ Effective Date: _____

What Pharmacy would you like us to use for your prescriptions? _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have Received a copy of the Notice of Privacy Practices for the above named practice.

Signature: _____ Date: _____

Office Use Only We were unable to obtain written acknowledgement of receipt of the Notice of Privacy Practices because:

- 1. An emergency existed and a signature was not possible
2. The individual refused to sign
3. A copy was mailed with a request for a signature by return mail
4. Unable to communicate with patient due to _____
5. Other _____