WESTERN WAKE WELLNESS, PLLC
PEDIATRIC HEALTH HISTORY

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

PATIENT INFORMAITON

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: ________________ DOB: _______________

Father's Name: ___________________________ Cell Phone: ________________ DOB: _______________

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 writer acknowledgement of receipt of the Notice of Privacy 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 ____