



" to teach, to empower, to heal "

EMR Patient Information Sheet

Westside Pediatric Clinic, P.C.

Please visit www.westsidepediatrics.com for up to date information

Please choose your **PRIMARY** physician:

Deborah Purcell, M.D. Paul Thomas, M.D. Eman Lutfi, M.D.
 Lori Hankenson, M.D. Alice Eaton, M.D.

Patient Information:

D.O.B. Patients Full Name _____
Sex

Home Address

Sibling(s): _____
Name Sex D.O.B

Name Sex D.O.B

Primary Guardian: (who the patient resides with)

D.O.B. Sex Full Name SSN #

Phone #1 Phone #2 Occupation Email

Insurance Company Subscriber's Name/ ID #/ Policy # Copay Amount \$

Secondary Guardian:

D.O.B Sex Full Name SSN #

Phone #1 Phone #2 Occupation Email

Address (if different from above)

Insurance Company Subscriber's Name/ ID #/ Policy # Copay Amount \$

Third Contact: (if unable to reach you directly)

Relation to Patient Full Name Phone Number(s)

I realize I am responsible to pay all non-covered services. I acknowledge this information is true and accurate and to the best of my ability.

Signature Relation to Patient Date