

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth Date:	Age:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Street address:		Social Security no.:		Home phone #.:
City:	State:	ZIP Code:		
Other family members seen here:				
Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other

PARENT(S) / LEGAL GUARDIAN INFORMATION

Mother's Last Name:	First:	Middle:	Social Security Number	Birth Date:	
Street Address: <input type="checkbox"/> Check if same as above			Home Phone:	Work Phone:	Cell Phone:
Occupation:	Employer:	Employer address:			
Father's Last Name:	First:	Middle:	Social Security Number:	Birth Date:	
Street Address:			Home Phone:	Work Phone:	Cell Phone:
Occupation:	Employer:	Employer Address:			
Is this patient covered by insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist for copying)

Insurance Company (Mother):	Insurance Carrier Name:	Ins. Phone Number		
Is patient covered by this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number:	Group or Plan Number:	Co-Payment:	Deductible:
			\$	\$
Insurance Company (Father):	Insurance Carrier Name:	Ins. Phone Number		
Is patient covered by this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number:	Group or Plan Number:	Co-Payment:	Deductible:
			\$	\$
Insurance Company (Patient) <input type="checkbox"/> PeachCare <input type="checkbox"/> Medicaid <input type="checkbox"/> Peach State <input type="checkbox"/> Amerigroup <input type="checkbox"/> WellCare				
Policy No.:		Effective Date:		

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to the physician. **I understand that I am financially responsible for any balance or service not covered by my insurance.** I also authorize Providence Pediatrics, LLC or insurance company to release any information required to process my claims. I authorize a copy of this consent to be used in place of the original. I also authorize release private health information to other providers involved in my child's care.

Patient/Guardian signature

Date