PATIENT INFORMATION

Child's Name Last:________________First: ________________ Birthday:________________

Street Address:________________________City:_____________State:_______ Zip:________

Home Phone:_______________________ Cell Phone: _______________________________

Sex: _________ Child resides with: (please circle one) Mother Father Both Other

Address where child resides: (if different than above)

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Mother's Name	**Father's Name**
First: Last:	First: Last:
Birthday:	Birthday:
SS#:	SS #:
Phone#:	Phone#:
Employer:	Employer:
Employer Phone #:	Employer Phone #:

List Name and Birthday of Siblings currently being seen in this office:

Insurance Information:

Name of Insurance: Policy/ I.D. #: Group #:

Name of Insured: Birthday of Insured:

SS # of Insured: Secondary Insurance? Yes No

Type of Secondary Insurance:

Information completed on this form is good for 90 days. Please sign on first day of completion. In the event your information has not changed in 90 days you may sign and date stating the information given is the same. Please verify that information is correct in our system before signing.

Signed__________________________ Date:______________ Signed__________________________ Date_______________

Signed__________________________ Date:______________ Signed__________________________ Date_______________

OUR OFFICE WILL BILL ONLY THOSE INSURANCE WITH WHICH WE ARE CONTRACTED. WE DO NOT BILL SECONDARY OR AUTO INSURANCE. I authorize SNELLVILLE PEDIATRICS, P.C. to release any medical information necessary to representatives of my insurance company for routine chart review, processing of claims, and to request payment of insurance benefits. I also authorize payment of medical benefits to SNELLVILLE PEDIATRICS, P.C. for all claims they file on my behalf. I understand that even though SNELLVILLE PEDIATRICS, P.C. is filing my claims, I am ultimately responsible for any balance on the account. I acknowledge that I have received a copy of SNELLVILLE PEDIATRICS, P.C. Privacy Practices pursuant to HIPAA regulations. I hereby acknowledge that it is the policy of this office that all payments (including co-pays, deductibles, and co-insurance) are to be made at the time of service and that I am responsible for payment of services for the above patient/patient's.

________________________________ ______________________________ ____________________

Signature Relationship to patient Date