MIDDLE GEORGIA PEDIATRICS, LLC

(PLEASE PRINT AND FILL OUT COMPLETELY)

PATIENT INFORMATION:

FULL NAME: _____ DOB: _____ MALE FEMALE

ADDRESS: _____ CITY : _____

STATE: _____ ZIP: _____ PHONE#: _____

PARENT/GUARDIAN INFORMATION:

**MOM'S NAME: _____ CELL# _____ WK # _____

MOM'S EMPLOYMENT & ADDRESS: _____

MOM'S SOCIAL SECURITY #: _____ DOB: _____

**DAD'S NAME: _____ CELL# _____ WK # _____

DAD'S EMPLOYMENT & ADDRESS: _____

DAD'S SOCIAL SECURITY #: _____ DOB: _____

EMAIL ADDRESS: _____**(USED FOR PATIENT PORTAL SET UP)**

NAME OF PREFERRED PHARMACY AND LOCATION: _____

PLEASE LIST ANY OTHER CHILDREN THAT COME TO THIS OFFICE: _____

IS YOUR CHILD UNDER THE CARE OF ANY SPECIALIST PHYSICIAN? _____ IF SO FOR WHAT REASON AND WHO IS THE PHYSICIAN? _____

HAS YOUR CHILD BEEN TO THE ER IN THE LAST 6 MONTHS? _____ IF SO WHAT WAS THE REASON FOR THE VISIT? _____

CURRENT INSURANCE INFORMATION: (PLEASE GIVE COPY OF CARDS)

NAME OF PRIMARY INSURANCE: _____

NAME OF SECONDARY INSURANCE: _____

INSURED'S NAME (PARENT): _____ DOB: _____

SOCIAL SECURITY #: _____

IF YOUR CHILD IS A NEWBORN PLEASE MAKE SURE YOU HAVE CALLED YOUR INSURANCE AND ADDED THE BABY TO YOUR INSURANCE. IF YOU HAVE NOT YOUR VISIT MAY NOT BE COVERED.

I CERTIFY THE INFORMATION ABOVE IS CORRECT. I THEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION TO ANY PARTY PAYORS TO BE USED BY THEM IN CONSIDERATION OF PAYMENT OF ANY CLAIMS RESULTING FROM MY CHILD'S TREATMENT. I FURTHER UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ANY BALANCE DUE AFTER INSURANCE HAS BEEN FILED. I ALSO UNDERSTAND THAT IF I HAVE NOT ADDED MY NEWBORN CHILD TO MY INSURANCE WITHIN THE APPROPRIATE AMOUNT OF TIME ALLOWED BY MY INSURANCE THAT I WILL BE RESPONSIBLE FOR THE BALANCE. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL. (REVISED 8/8/19)

SIGNATURE OF PARENT: _____ DATE: _____