## Greater Atlanta Pediatrics, PC

#  **Patient REGISTRATION FORM**

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| --- | --- |
| Today’s Date: [Date] | Previous (if any) PCP: [PCP] |

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|  PATIENT INFORMATION

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| Patient’s Full Name (First,MI,uffix):  |  |  |

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| Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: |
|  | [Legal Name] | [Former Name] | [Birthday] | [Age] |  |

Address: [Address/ P.O Box, City, ST ZIP Code]

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| Social Security no.: | Home phone no.: | Cell phone no.: |
| [SS#] | [Phone] | [Phone] |
| Occupation: | Employer: | Employer phone no.: |
| [Occupation] | [Employer] | [Phone] |

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| How did you find us? Please Check one/Specify:Chose clinic because/referred to clinic by (Please choose one option): |  | [Doctor’s name] |
|  |  | Other |

Other family members seen here: Siblings Names and Birthdates: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**INSURANCE INFORMATION** (Please give your insurance card to the receptionist.) Is Patient covered by insurance? Yes / No (Self-Pay)

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| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
| [Responsible party] | [Birthday] | [Address] | [Phone] |
| Is this person a patient here? |  | Is this patient covered by insurance? |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
| [Occupation] | [Employer] | [Address] | [Phone] |

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

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| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
| [Name] | [SS#] | [Birthday] | [Group #] | [Policy #] | $[Co-pay] |

Patient’s relationship to subscriber: [Choose an item] | or Specify Other: [Relationship to subscriber]

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| Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: |
| [Secondary Insurance] | [Name] | [Group #] | [Policy #] |

Patient’s relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]IN CASE OF EMERGENCY

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| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
| [Friend or relative name] | [Relationship] | [Phone] | [Phone] |

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| pharmacy informationPharmacy Name: Address: Telephone number: |
| family/Contact INformationPatient resides primarily with: Both Parents \_\_\_\_\_ Mother\_\_\_ Father\_\_\_ Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parents are: Married­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_ Divorced\_\_ Separated\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Mother’s Name and Birth Date: | Home Phone Number: | *Mobile Number:* | *E-Mail:* | Occupation:  | Employer &Work Number:  |
| The best way to reach me is: \_\_Home Number \_\_Mobile Number \_\_E-mail |
| Father’s Name and Birth Date: | Home Phone Number: | Mobile Number: | *E-Mail:* | Occupation: | Employer &Work Number: |
| The best way to reach me is: \_\_Home Number \_\_Mobile Number \_\_E-mail |

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Greater Atlanta Pediatrics, PC or insurance company to release any information required to process my claims. I give permission for Greater Atlanta Pediatrics to contact me via-email and/or text message.

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|  | Patient/Guardian signature |  | Date |  |