Patient Registration- Required Yearly

Patient Information (Please list all children in the family and use legal name)

Patient Name: _____ D.O.B. _____ Sex: Male / Female

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Address:_____**City:**_____**Zip:**_____

How would you like to be reminded of your appointments?

*Phone#*_____ *text#*_____ *email* _____

Parental/ Guardian information

Mother's Name _____ D.O.B. _____/_____/_____

Home# _____ Cell# _____ Email _____

Address (**If different from child**) _____

Place of Employment _____ Occupation/Title _____

Father's Name _____D.O.B. _____/_____/_____

Home# _____ Cell# _____ Email _____

Address (**If different from child**) _____

Place of Employment _____ Occupation/Title _____

If parents are divorced or separated please fill out this section:

Who has physical custody?_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Primary Insurance information

Name (**Policy Holder**) _____ D.O.B. (**Policy Holder**) _____

Address of policy holder if other than listed above_____

*Relationship to Patient _____ Insurance company_____

Member ID:_____ Group #:_____

Secondary Insurance ☐ Yes ☐ No

Emergency Contact (other than parents)Name:_____ phone:_____

Please select a pharmacy:

☐ Walgreens	☐ CVS	☐ Kroger Shiloh Square	☐ Publix-Cobb Pkwy	Other: _____
2779 Cobb Pkwy	2782 N. Cobb Pkwy	3895 Cherokee St	22774 N. Cobb Pkwy.	_____
(770)795-1638	(770)420-1092	(770)218-7033	(770) 426-3246	_____

In order to provide the best care for your child/children, we will at some visits ask you to fill out questionnaires on your child's development/behavior/symptoms. These forms are screening tools. These screenings may or may not be completely covered by your insurance company. If they are not covered, the cost would be minimal. They are necessary for us to provide adequate care.

Financial/Privacy Policies (HIPAA)

_____ (Initial) I authorize East Cobb Pediatrics and Adolescent Medicine to treat the above named child.

_____ (Initial) I authorize release of medical and billing information to the insurance company so that payment for charges can be processed.

_____ (Initial) I authorize and direct the insurance company to pay the portion of charges due to EC Pediatrics.

_____ (Initial) I acknowledge that a copy of the East Cobb Pediatrics and Adolescent Medicine Financial Policy and Privacy Policies have been made available.

_____(Initial) I authorize EC Pediatrics to leave voice mail messages containing protected healthcare information at the following numbers: (H)_____ (Other)_____

FORM COMPLETED BY: ☐ MOM ☐ STEP-MOM ☐ DAD ☐ STEP-DAD OTHER_____

Signature _____ Date _____/_____/ 2017

PRINT NAME _____