ABC PEDIATRIC GROUP, P.C.
Patient Registration Form

PATIENT INFORMATION *(Please Print ONLY)*

Patient's Last Name:	First Name:	M.I.:	Birth Date: – –	Age: ____ Sex: ··· Male ··· Female Social Security No.: / /

Street Address:	City:	State:	ZIP:	Home Phone No.: ( ) –

Other family members treated here:

Referred to us by: *(Please check ONE box):*	··· Dr. _____	··· Insurance Plan:	··· Hospital:

··· Family Member:	··· Friend:	··· Close to home/work	··· Yellow Pages	··· Other:

PARENT(S) / LEGAL GUARDIAN INFORMATION

Mother's Last Name:	First Name:	M.I.:	Birth Date: – –	Social Security No.: / /

Street Address: ··· *Check here if same as above*	Home Phone No.: ( ) –	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

Occupation:	Employer:	Employer's Address:

Father's Last Name:	First Name:	M.I.:	Birth Date: – –	Social Security No.: / /

Street Address: ··· *Check here if same as above*	Home Phone No.: ( ) –	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

Occupation:	Employer:	Employer's Address:

INSURANCE INFORMATION

Is patient covered by insurance? ··· Yes ··· No	Person responsible for bill:	*Please give insurance card to the Receptionist for copying*

Mother's Insurance Company:	Insurance Address:	Insurance Phone No.:) –

Is patient covered by this policy? ··· Yes ··· No	Policy Number:	Group or Plan Number:	Co-Payment: $	Deductible: $

Is patient covered by insurance? ··· Yes ··· No	Person responsible for bill:	*Please give insurance card to the Receptionist for copying*

Father's Insurance Company:	Insurance Address:	Insurance Phone No.:) –

Is patient covered by this policy? ··· Yes ··· No	Policy Number:	Group or Plan Number:	Co-Payment: $	Deductible: $

Patient's Insurance Company:	··· PeachCare ··· GBHC ··· Peach State ··· Amerigroup ··· WellCare

Policy Number:	Effective Date:

IN CASE OF EMERGENCY

Name of friend / relative (not living at same address):	Relationship to patient:	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

CONSENT

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 *ABC PEDIATRIC GROUP, P.C.* (the "Group"). I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

Patient / Guardian:

_____ _____ _____

Name *(Please Print)* Signature Date