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| **MIDDLE GEORGIA PEDIATRICS, LLC** | | | | | | | | | | |
| **NEW PATIENT INFORMATION** (PLEASE PRINT) | | | | | |  | | | Date: | |
|  | | | | | | | | | | |
| NAME | | | | | | | | | SEX: M F | |
| S.S.# | | | | | | | | | BIRTHDATE | |
| ADDRESS | | | | | | | | | PHONE | |
| CITY | | | | | STATE | | | | ZIP | |
|  | | | | | | | | | | |
| **PARENT/GUARDIAN INFORMATION** | | | | | | | | | | |
|  | | | | | | | | | | |
| **FATHER’S NAME** | | | | | | | | CELL# | | |
| S.S.# | | | | | | | | BIRTHDATE | | |
| D.L.# | | | | | ADDRESS | | | | | |
| PHONE | | | | | CITY | | | STATE | | ZIP |
| EMPLOYER | | | | | | WORK PHONE | | | | |
| ADDRESS | | | | | | | | | | |
| **MOTHER’S NAME** | | | | | | | | CELL# | | |
| S.S.# | | | | | | | | BIRTHDATE | | |
| D.L.# | | | | | ADDRESS | | | | | |
| PHONE | | | | | CITY | | | STATE | | ZIP |
| EMPLOYER | | | | | | WORK PHONE | | | | |
| ADDRESS | | | | | | | | | | |
|  | | | | | | | | | | |
| **NAME OF PREFERRED PHAMACY AND LOCATION** | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | |
| **PRIMARY POLICY** | | | INSURANCE COMPANY | | | | | | | |
| ADDRESS | | | | | | | | | | |
| CITY | | | | | | | STATE | | | ZIP |
| NAME OF INSURED | | | | | | RELATIONSHIP | | | | |
| POLICY# | | | | | | | GROUP# | | | |
| **SECONDARY POLICY** | | | INSURANCE COMPANY | | | | | | | |
| ADDRESS | | | | | | | | | | |
| CITY | | | | | | | STATE | | | ZIP |
| NAME OF INSURED | | | | | | RELATIONSHIP | | | | |
| POLICY# | | | | | | | GROUP# | | | |
|  | | | | | | | | | | |
| INSURANCE IS FILED BY THIS OFFICE AS A COURTESY TO THE PATIENT. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OS INSURANCE COVERAGE. IT IS THE PARENTS RESPONSIBILITY TO BE AWARE OF BENEFITS THAT THEIR INSURANCE PROVIDES FOR WELL CHILD CARE AND SICK VISITS. ALL INSURANCE CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. | | | | | | | | | | |
| **INSURANCE AUTHORIZATION AND ASSIGMENT** | | | | | | | | | | |
|  | | | | | | | | | | |
| I hereby authorize Middle Georgia pediatrics, LLC to furnish information to insurance carriers concerning my illness and/or treatment and hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance | | | | | | | | | | |
|  | | | | | | | | | | |
| **DATE** | |  | | **SIGNATURE** | | | | | | |
|  |  | | | | |  | | |  | |
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