



Atlanta Pediatric Partners Patient Registration Form

Patient Information:

Patient Name	Last	First	Middle	Date of Birth	Gender (Circle One) M F
Street			Apt.	Patient's Social Security Number	
City	State	Zip		Home Phone Number	

Parent Information: Child lives with ? _____

Mother's Name	Last	First	Middle	Father's Name	Last	First	Middle
Mother's Date of Birth		Mother's SS#		Father's Date of Birth		Father's SS#	
Employer				Employer			
Business Number				Business Number			
Mobile Number				Mobile Number			
Mother's Email Address				Father's Email Address			

Referred By:

Name	Other
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Emergency Contact:

Name	Phone Number
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Primary Insurance:

Insurance Company Name:
Claims Address:
Name of Policy Holder:
Member Identification Number
Group Number

Who should correspondence regarding bills go to ? **Mother** or **Father**
I authorize the release to my Insurance Company of any information required for processing claims. Research, chart reviews and quality control.

Signature _____ Date _____
(Guarantor, if minor)

I hereby assign payment directly to Atlanta Pediatric Partners, P.C. for medical benefits payable for these services. Although covered by insurance, I understand I am responsible for all charges unless covered by a managed care plan, Medicaid/Peach Care, or Worker's Compensation.

Signature _____ Date _____

As a responsible party for the above named patient, I authorize Atlanta Pediatric Partners. P.C to render necessary treatment in my absence. I authorize the release of any personal, demographic or medical information required to provide continuing and/or consultative medical care.

Signature _____ Date _____