Print Form

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 or 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

Emergency Contact:

Name	Phone Number

Primary Insurance:

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

Revision Date: 8/13/2010

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 _____