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(770) 518-8718 fax

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Pediatric Physicians, PC

Child Registration

Child's full name: _____ DOB: _____ Male: _____ Female: _____ PPPC Account # _____

Additional children: (if any)

Child's full name: _____ DOB: _____ Male: _____ Female: _____ PPPC Account # _____

Child's full name: _____ DOB: _____ Male: _____ Female: _____ PPPC Account # _____

Child's full name: _____ DOB: _____ Male: _____ Female: _____ PPPC Account # _____

Does child/children live with both parents? **Y/N** If not, who is the legal guardian? _____

Child's address: _____ City: _____ State: _____ Zip: _____

Best contact phone #: _____ Who's phone is this? _____ Alternative phone numbers: _____

If you would like to join our email newsletter list, enter your email address: _____

Father's Information:

Father's full name: _____ DOB _____ SS # _____

Father's address: _____ City: _____ State: _____ Zip: _____

Father's home phone: _____ Cell phone: _____ Business phone: _____

Mother's Information:

Mother's full name: _____ DOB _____ SS # _____

Mother's address: _____ City: _____ State: _____ Zip: _____
(if different from father's)

Mother's home phone: _____ Cell phone: _____ Business phone: _____

Emergency/Insurance/Pharmacy:

Whom should we call other than parents? _____ Phone # _____ Relationship _____

Who referred you to our office? _____

Insurance Information: Who is the policy holder for the insurance? _____ Date of birth: _____

Who is responsible for co-pays? _____ Who should receive any bills? _____ Is there secondary insurance? _____

What pharmacies does your family usually use? If you don't know the address/zip/phone, list cross streets or location [optional, to help with e-prescribing]

Name: _____ Address/location/Zip: _____ Phone: _____

Name: _____ Address/location/Zip: _____ Phone: _____

- It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
- CHARGES FOR OFFICE VISITS MUST BE PAID AT THE CONCLUSION OF EACH VISIT.
- If this account is assigned for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
- To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
- I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **Pediatric Physicians, PC**.
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
- I have been given the opportunity to review the Notice of Privacy Practices for **Pediatric Physicians, PC**.

SIGNED _____ DATE _____