

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

PATIENT REGISTRATION INFORMATION

Date _____ Patient Acct # _____

PATIENT INFORMATION

Name: _____
First Middle Initial Last

Date of Birth: _____ Sex: Male Female Social Security#: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Mom Work Phone: _____ Mom's Cell: _____

Dad's Work Phone: _____ Dad's Cell: _____

Email Address: _____

GUARANTOR INFORMATION *(Responsible Party / Will be SELF if patient is 18 yrs or older)*

Name: _____
First Middle Initial Last

Date of Birth: _____ Sex: Male Female Social Security#: _____

Marital Status: Single Married Divorced Other Relation: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Name & Address of Employer: _____

EMERGENCY CONTACTS

Emergency Contact Name: _____ Relation: _____

Phone #1: _____ Phone #2: _____

Nearest Relative (not living with you): _____ Relation: _____

Phone #1: _____ Phone #2: _____

INSURANCE INFORMATION *(copy of insurance card required to file insurance)*

Primary Insurance Carrier Name: _____

Address: _____ City, State, Zip: _____

Insurance Phone #: _____ Effective Date: _____

Policy Holder Name: _____ Group #: _____ Group Name: _____

Relationship to Patient: _____ Birthdate: _____ Social Security #: _____

Your signature below indicates your consent for treatment of /as patient and responsibility for the payment of the bill. Thank you.

Guardian or Patient Signature Date: _____