GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

PATIENT INFORMATION

Name:_____
First **Middle Initial** **Last**

Date of Birth:_____ **Sex:** □ Male □ Female

Address:_____ **City, State, Zip:**_____

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

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

Email Address:_____
(We send out appointment notices via email) *We can text appointment reminders.*

*Pharmacy Name*_____ *Pharmacy 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:**_____

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 #:**_____

Name & Address of Employer_____

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

_____ **Date:**_____
Guardian or Patient Signature