

# Sandy Springs Pediatrics and Adolescent Medicine

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Father's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

## Emergency Contacts

In case of emergency contact: Name \_\_\_\_\_

Phone \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Insurance Information

### Primary Insurance

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insured Name \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

### Secondary Insurance

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Insured Name \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

## Other Children

Name \_\_\_\_\_ M / F Name \_\_\_\_\_ M / F

Name \_\_\_\_\_ M / F Name \_\_\_\_\_ M / F

## Consent for Medical Care and Assignment of Benefits

I authorize Sandy Springs Pediatrics to provide medical care for my child/children. I authorize payment of medical benefits directly to Sandy Springs Pediatrics for services provided. I authorize physician to release any information required to process my claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_