WEST ATLANTA PEDIATRICS – Patient Information Annual Update

PATIENT INFORMATION

Patient Name: _____ **Sex:** _____ **Date of Birth:** _____

Physical Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Child's Cell Phone (if over 16): _____

Pharmacy Name: _____ **Pharmacy Phone#** _____

Pharmacy Location (Street, City) _____

MOTHER'S INFORMATION

Address if different than above: _____

Mother's Name: _____ **DOB:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

FATHER'S INFORMATION

Address if different than above: _____

Father's Name: _____ **DOB:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

INSURANCE INFORMATION

Insurance Company: _____

Subscriber's Name: _____ **Date of Birth:** _____

List names & birthdates of all siblings: _____

Emergency Contact Name (other than parent) : _____

Relationship: _____ **Phone Number:** _____

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or West Atlanta Pediatrics accept assignment.

Authorization To Release Medical Information: I hereby authorize West Atlanta Pediatrics to release any information necessary for my course of treatment.

Parent Signature _____ **Date:** _____