WEST ATLANTA PEDIATRICS – New Patient Information Sheet

PATIENT INFORMATION

Patient Name: ______________________________ Sex: ________ Date of Birth: ______________
Physical Address: ______________________________ City: ______________________________ State: __________
Zip Code: __________ Primary Phone: ______________ Secondary Phone: ______________________
E-Mail Address: ______________________________
Child's Cell Phone (if over 16): ______________________________
Pharmacy Name: ______________________________ Pharmacy Phone# ______________________________
Pharmacy Location (Street, City) ______________________________

MOTHER'S INFORMATION

Mother's Name: ______________________________ Date of Birth: ______________
Maiden Name: ______________ (Needed to access child's Immunizations in GRITS)
Mailing Address: ______________________________ City: ______________________________ State: __________
Zip Code: ______________ Home Phone: ______________________ Cell Phone: ______________________
Employer: ______________________________ Work Phone: ______________________
Social Security Number ______________________________

FATHER'S INFORMATION

Father's Name: ______________________________ Date of Birth: ______________
Mailing Address: ______________________________ City: ______________________________ State: __________
Zip Code: ______________ Home Phone: ______________________ Cell Phone: ______________________
Employer: ______________________________ Work Phone: ______________________
Social Security Number ______________________________

PRIMARY INSURANCE INFORMATION

Insurance Company: ______________________________
Subscriber's Name: ______________________________ Date of Birth: ______________

SECONDARY INSURANCE INFORMATION

Insurance Company: ______________________________
Subscriber's Name: ______________________________ Date of Birth: ______________

Which office will your child be seen at primarily? Dallas_____ Lithia Springs_______
List names & birthdates of all siblings: ______________________________
List any medication allergies: ______________________________
Any significant health problems? ______________________________
Who was your child's previous physician? ______________________________

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.

I acknowledge that I have been given a copy of West Atlanta Pediatrics office policies.

Parent Signature ______________________________ **Date:** ______________________