ABC PEDIATRIC GROUP, P.C.
Patient Registration Form

PATIENT INFORMATION *(Please Print ONLY)*

Patient's Last Name:	First Name:	M.I.:	Birth Date: – –	Age: ____ Sex: ☐ Male ☐ Female Social Security No.: / /

Street Address:	City:	State:	ZIP:	Home Phone No.: ( ) –

Other family members treated here:

Referred to us by: *(Please check ONE box):*	☐ Dr. _____	☐ Insurance Plan:	☐ Hospital:

☐ Family Member:	☐ Friend:	☐ Close to home/work	☐ Yellow Pages	☐ Other:

PARENT(S) / LEGAL GUARDIAN INFORMATION

Mother's Last Name:	First Name:	M.I.:	Birth Date: – –	Social Security No.: / /

Street Address: ☐ *Check here if same as above*	Home Phone No.: ( ) –	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

Occupation:	Employer:	Employer's Address:

Father's Last Name:	First Name:	M.I.:	Birth Date: – –	Social Security No.: / /

Street Address: ☐ *Check here if same as above*	Home Phone No.: ( ) –	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

Occupation:	Employer:	Employer's Address:

INSURANCE INFORMATION

Is patient covered by insurance? ☐ Yes ☐ No	Person responsible for bill:	*Please give insurance card to the Receptionist for copying*

Mother's Insurance Company:	Insurance Address:	Insurance Phone No.: ( ) –

Is patient covered by this policy? ☐ Yes ☐ No	Policy Number:	Group or Plan Number:	Co-Payment: $	Deductible: $

Is patient covered by insurance? ☐ Yes ☐ No	Person responsible for bill:	*Please give insurance card to the Receptionist for copying*

Father's Insurance Company:	Insurance Address:	Insurance Phone No.: ( ) –

Is patient covered by this policy? ☐ Yes ☐ No	Policy Number:	Group or Plan Number:	Co-Payment: $	Deductible: $

Patient's Insurance Company:	☐ PeachCare ☐ GBHC ☐ Peach State ☐ Amerigroup ☐ WellCare

Policy Number:	Effective Date:

IN CASE OF EMERGENCY

Name of friend / relative (not living at same address):	Relationship to patient:	Work Phone No.: ( ) –	Cell Phone No.: ( ) –

CONSENT

The above information is true to the best of my knowledge. I give consent for treatment and authorize that my insurance benefits for covered services be paid directly to ABC PEDIATRIC GROUP, P.C. (the "Group"). I understand that I am financially responsible for any balance or service not covered by my insurance company. I authorize the Group and/or the insurance company to release any information required to process my claim. I also authorize a copy of this Consent to be used in lieu of the original. I further authorize the release of private health information to other providers involved in my child's care.

Patient / Guardian:

Name *(Please Print)*	Signature	Date